Long-Term and Behavioral Health Committee
-- Tentative Agenda --
September 14, 2007

I. Welcome and Announcements

II. Approval of Minutes of May 18, 2007 Committee Meeting

III. Recommendations regarding Nursing Facility Portions of the Proposed 2008 SMFP: *(No petitions or comments were received regarding the Nursing Facility Portions of the Proposed Plan.)*

Development of a recommendation to the SHCC regarding Nursing Care Facilities.

IV. Recommendations regarding the Adult Care Homes Portions of the Proposed 2008 SMFP: ***(The divider page related to Adult Care Homes is printed on Yellow paper)***

A. Consideration of Adult Care Home Petition and Agency Report: Housing Authority of the City of Wilson – Edward R. Jagnandan *(Attachment – Adult Care Home Petition)*

B. Development of a recommendation to the SHCC regarding Adult Care Homes.

V. Recommendations regarding Home Health Portions of the Proposed 2008 SMFP: *(No petitions or comments were received regarding the Home Health Portions of the Proposed Plan.)*

Development of a recommendation to the SHCC regarding Home Health Services.

VI. Recommendations regarding the Hospice Portions of the Proposed 2008 SMFP: ***(Divider pages related to Hospice are printed on Pink paper)***

A. Consideration of Hospice Petitions and Agency Reports:
(The Hospice Inpatient Attachment includes the Agency Report regarding Petitions for Inpatient Hospice 1 through 6)

1. Petition Inpatient Hospice – 1: Hospice and Palliative Care Cleveland County *(Attachment - Hospice Inpatient 1)*
2. Petition Inpatient Hospice – 2: Hospice and Palliative Care (Forsyth County) *(Attachment - Hospice Inpatient 2)*
3. Petition Inpatient Hospice – 3: Hospice of Gaston County *(Attachment - Hospice Inpatient 3)*
4. Petition Inpatient Hospice – 4: Haywood Regional Medical Center Hospice *(Attachment - Hospice Inpatient 4)*

5. Petition Inpatient Hospice - 5: Johnston Memorial Hospital Authority *(Attachment - Hospice Inpatient 5)*
6. Petition Inpatient Hospice – 6: Angel Hospice and Palliative Care (Macon County) *(Attachment Hospice Inpatient 6)*

B. Consideration of Comments *(Attachment – Hospice Comment)*

C. Development of a recommendation to the SHCC regarding Hospice Services.

VII. Recommendations regarding ESRD Dialysis Portions of the Proposed 2008 SMFP: ***(Divider page related to ESRD is printed on Ivory paper)***

A. Consideration of ESRD Petition, Comments and Agency Report: Transylvania County – Steven E. Smith

B. Development of a recommendation to the SHCC regarding Dialysis Facilities.

Behavioral Health Issues

Agency Recommendations ***(Divider page related to Behavioral Health Chapters is printed on Salmon paper)***

VIII. Recommendations regarding Psychiatric Inpatient Services Portions of the Proposed 2008 SMFP: ***(Blue color divider page)***

A. Consideration of Policy PSY-2 Change *(Policy Attachment)*

B. Consideration of Psychiatric Inpatient Services Petition and Agency Analysis: *(Attachment):* Appalachian Regional Healthcare System –Tim Ford

C. Consideration of Comments *(Attachment – Psychiatric Comments)*

D. Development of a recommendation to the SHCC regarding Psychiatric Inpatient Services.

IX. Recommendations regarding Substance Abuse Inpatient and Residential Portions of the Proposed 2008 SMFP: ***(Buff color divider page)***

A. Consideration of Substance Abuse Petition and Agency Analysis: Path of Hope, Inc. – Angie Gerock Banther *(Attachment)*

B. Development of a recommendation to the SHCC regarding Substance Abuse Inpatient and Residential Services.

X. Recommendations regarding ICF-MR Portions of the Proposed 2008 SMFP: ***(Green color divider page)***

A. Consideration of Comment: *(Attachment – ICF-MR Comment)*

B. Development of a recommendation to the SHCC regarding ICF-MR Services.

XI. Other Business

XII. Adjournment

Adult Care Home Petition
Received Regarding Proposed 2008 State Medical Facilities Plan

Attached are:

1) **Agency Report: Petition from the Housing Authority of the City of Wilson.**

2) **Petition from the Housing Authority of the City of Wilson and additional information.**

AGENCY REPORT:

Proposed 2008 Plan

Notes related to **Adult Care Home Petition** from the **Housing Authority of the City of Wilson,** Wilson County

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Request

The **Housing Authority of the City of Wilson** submitted a petition for a need determination for 58 adult care home beds in Wilson County.

Background Information

The adult care home bed need determination methodology uses basic principles utilized in the SMFP nursing facility assumptions and methodology. The methodology projects future bed utilization based on age-specific use rates applied to each county's projected age-specific civilian population. The projected bed utilization is adjusted for each county's "planning inventory" of adult care home beds to determine a surplus or deficit of beds. If any county's deficit is 10% to 50% of its total projected bed need, and the average occupancy of licensed beds in the county, excluding Continuing Care Retirement Communities, is 85% or greater based on utilization data reported on 2007 Renewal Applications, the need determination is the amount of the deficit rounded to 10. If any county's deficit is 50% or more of its total projected bed need, the need determination is the amount of its deficit rounded to closest number divisible by 10. As noted in the Proposed 2008 Plan, the planning inventory of beds is subject to change based on whether or not defined conditions have been met to allow for continued development of the "exempt" or "pipeline" beds that have been included in the inventory, settlement or litigation, and other inventory changes.

It should be noted that any person may submit a certificate of need application for approval for a need determination in the Plan. Therefore, should there be a need determination in the 2008 Plan, the CON review could be competitive and there is no guarantee that the petitioner would be the approved applicant.

The petition was provided to the following for comment: North Carolina Assisted Living Association, North Carolina Association of Long Term Care Facilities, North Carolina Association of Non-Profit Homes for the Aging, North Carolina Health Care Facilities Association, and North Carolina Hospital Association. Attached is a written comment received from the North Carolina Association of Long Term Care Facilities.

Analysis of Petition

Wilson County has seven adult care home facilities with a total of 483 beds. Using population projections for the year 2011, the standard methodology indicates a projected surplus of 174 adult care home beds in Wilson County. Therefore, based on the standard methodology, there is not a need determination in Wilson County.

Based on information reported on year 2007 Licensure renewal applications, there was a vacancy rate of approximately 24% in the free standing (not nursing facility based) adult care homes in the county. Nursing facility based adult care homes reported a vacancy rate of 54%

on the 2007 License applications in 59 beds. It is interesting to note that one of the nursing facilities reduced the number of licensed beds from 20 to 12 beds within the last year.

It is not clear why persons could not be placed in existing adult care home beds if there are empty licensed beds. Based on a 24% vacancy rate, approximately 103 beds in free standing adult care homes would be empty in addition to there being empty adult care home beds in nursing facilities.

The petitioner states that the request is based on allowing low-income seniors and disabled adults to age in place in their homes and avoid premature institutionalization at a higher cost to the State and Wilson County. The petitioner indicates that persons could be moved into the facility from other Authority locations which appears to contradict the concept of aging in place.

The petitioner notes that several residents were admitted to nursing facilities. However, per the Adult Care Licensure Section, based on information from the Wilson County Department of Social Services, housing authority residents were admitted to adult care home beds.

It also is not clear how there would be a lower cost to the State and County since the residents would presumably qualify for Medicaid whether they were in the Housing Authority facility or an existing adult care home.

The petitioner requests a revision of the methodology to include factors other than age. Petitions for changes to the 2008 Plan methodologies should have been be filed by March 7, 2007. However, petitions for methodology revisions may be filed by February 29, 2008 for consideration for inclusion in the Proposed 2009 Plan.

The Agency notes concern about a precedent being set if the petition were to be granted given the number of requests that could be made in the future by housing authorities across the state.

One of the reasons noted by the Wilson County Board of Commissioners for supporting the adult care home beds is its Medicaid costs. This may not be as much an issue given the legislation passed this year removing this as a cost to Counties.

Statements are made that the building would require minimum capital investment to comply with adult care home licensing requirements. However, an evaluation of the building by the Division's Construction Section indicated numerous changes that would be needed. Based on this information, it is the Division's understanding that the petitioner may be reconsidering renovation of the existing building in favor of new construction.

In the talking points, it states that no medical services will be provided and healthcare services would be contracted with existing providers. But, to be licensed as an adult care home, they would need to have staff to meet licensure requirements.

It is noted in the letter from the DHHS that persons in Tasmin Towers received home care services from existing agencies and also received assistance under the Community Alternatives Program for Disabled Adults. Also noted is the State/County Special Assistance

In-Home Option administered by the Wilson County DSS which the Division of Aging and Adult Services identified as an alternative to placement in an adult care home.

Agency Recommendation

With regard to disposition of this petition, the Agency recommends that the petition be denied.

Options the Petitioner May Wish to Consider.

Acquiring an existing adult care home in Wilson County. Acquisition of an existing facility does not require a Certificate of Need if prior written notice of the acquisition is provided to the Certificate of Need Section.

Development of one or more free standing Family Care Homes which have six or fewer adult care beds and do not require receipt of a Certificate of Need.

While the petitioner has indicated they had considered development of "Multi-Unit Assisted Housing with Services (MAHS)", they may wish to re-consider this option given information regarding the extent to which Tasmin Towers would need to be renovated to meet Adult Care Home licensure requirements.

Use of alternatives as outlined in the DHHS letter regarding existing services available for residents of the housing authority.

The petitioner is encouraged to discuss options with the Division of Health Service Regulation Adult Care Licensure Section, Acute and Home Care Licensure and Certification Section, and Certificate of Need Section and others regarding relevant policies, criteria, standards and statutory requirements.

Subject: RE: PetitionForAdultCareHomeBeds
From: "Lou Wilson" <lou@ncaltcf.com>
Date: Tue, 4 Sep 2007 15:29:29 -0400
To: "'Floyd Cogley'" <Floyd.Cogley@ncmail.net>

September 4, 2007

To: Mr. Floyd Cogley, Planner, Medical Facilities Planning Section

From: Lou B. Wilson, Executive Director, NC Association, Long Term Care

Re: Petition-Housing Authority, City of Wilson

The NC Association, Long Term Care Facilities opposes the petition from the Wilson Housing Authority to license 58 adult care home beds for the following reasons:

1) **The State Medical Facilities Planning Section clearly has an established methodology by which to project the need for adult care home beds. The law is clear. It would be unfair to existing adult care home providers to change methodology for one region of the state only.**
2) **Homes for the Aged including Family care Homes totals more than 500 licensed adult care home beds in Wilson County.**
3) **Approximately 25 % of the total licensed beds are vacant.**
4) **According to adult care home administrators in Wilson County the statement regarding the homes being too restrictive for admissions is a false assumption.**
5) **Licensed adult care homes in Wilson County have stated they stand ready to assist the Housing Authority with placement needs.**

Thank you for the opportunity to comment on this proposal.

Petition for Adjustments to Need Determinations
Adult Care Homes
by
Housing Authority of the City of Wilson

Petitioner:
Edward R. Jagnandan, Director
Housing Authority of the City of Wilson
P.O. Box 185,
Wilson, North Carolina 27894-0185
Phone: 252 291-2245
Fax: 252 291-0984

Statement of Request:

City of Wilson Housing Authority requests for an adjustment to the Need Determination to increase the number of adult home bed in the County of Wilson. The reason for our request is based on the need to allow low-income seniors and disabled adults to age in place in their homes and avoid premature institutionalization at a higher cost to the state and Wilson County. The Proposed 2008 State Medical Facilities Plan reports a surplus of 174 adult home care beds in Wilson County. However, within the City of Wilson Housing Authority alone, 17 residents have entered a nursing home due to the lack of adult care home alternative. We strongly believe that a pocket of low income, frail, under the poverty level, living alone resides at the housing authority that have no alternatives but a nursing home when no longer able to live independently. The criteria used by the State in determining need only include age. However, a national determinant of the demand for long care includes other important factors, living alone, under the poverty level and with multiple disabilities and health issues. We would like to request a revision of the methodology used by the State to include these factors in view of the demographies of Wilson County and the City of Wilson.

Proposed Adjustment Justification:

Wilson County has one of the largest concentrations of low income seniors/disabled adults, living alone, under the poverty level with multiple health and mobility problems. The methodology for determining demand for long term care is based not only on age, but income, multiple mobility problems and lack of caretakers (living alone). However, North Carolina only considers age in determining need. A market analysis conducted by City of Wilson Housing Authority identified over 10,000 senior/disabled adults, living alone, under the poverty level with multiple mobility and health problems in Wilson County. The Proposed 2008 State Medical Facility Plan determined that only 25.55 beds /1,000 residents are needed for the age category of 65-74 years. Using age as a determinant alone and based on our market analysis, you will need 253 beds for that age category alone. A phone interview to licensed adult care homes in the area revealed restrictions as to the type of residents that could be admitted. In addition, state plan

residents can only move to a shared accommodation unit with a bathroom shared by five individuals.

Housing authorities provide private accommodations in debt-free buildings, subsidized by the federal government and in compliance with federal regulations. Residents of public housing wish to remain in their homes where they have lived an average of ten years. Conversion of existing public housing facilities require a minimum of capital investment (less than $500,000) to comply with adult care home licensing requirements. All medical services are to be provided by existing healthcare providers in the area.

Disabled and elderly residents will enter nursing home prematurely if this adjustment is not approved. The cost to the county, state and taxpayers will continue to increase as this not only affects the quality of life of these residents but the cost to taxpayers, counties and the state. The per diem cost in a nursing home is $100/resident versus $45 in community care. With no debt service, taxes, capital costs, no profit incentive, coupled with a rental subsidy, these public housing facilities are able to provide higher quality of services. Over 100 housing authorities in nationwide have implemented assisted living services with excellent results.

Existing licensed adult care homes only admit residents that are not mobile impaired, have no symptoms of dementia or require more attention than the facility is willing to offer. Public housing staff was not successful in placing residents in the existing adult care home facilities. Housing authorities wanted to obtain a license to provide services in their federally regulated facilities but were unable due to the certificate of need and the moratorium on new beds. Several meetings were held with the State Department of Health & Human Services and local department of social services. All these meetings were unsuccessful in finding a care alternative. One suggestion was to obtain a certificate as a multi-unit assisted housing program. The problem with this suggestion is residents cannot receive 24-hour supervision as there is a state moratorium on home aide services. Most of the public housing residents are receiving homemaker services an average of five hours/week. However, as they become frailer, they need 24-hour supervision.

Providing 24-hour supervision to residents where they live is not an option in North Carolina, it is a necessity. We are enclosing a letter from the Department of Health describing all their programs/services and an option is not available to us.

The market analysis conducted by City of Wilson Housing Authority is available upon request. It gives evidence increasing the number of adult home care in the county will increase the options available to our residents; it will reduce Medicaid costs and increase the quality of care. Also included is the Board of County Commissioners' resolution passed unanimously on April 2nd, 2007 requesting the increase in adult home care beds.

Wilson County Board of Commissioners

RESOLUTION

Need for Additional Adult Care Home Beds in Wilson County

WHEREAS, Wilson County pays a percentage of the expenditures for services to Medicaid eligible citizens, and the cost of caring for low-income seniors and disabled adults in nursing homes is twice as high as in an adult care home, and

WHEREAS, the counties share of Medicaid reimbursements has increased 96% since 2000 and is projected to total more than $517 million during the current fiscal year, and

WHEREAS, Wilson County and the City of Wilson have the largest concentration in the state of low income seniors and disabled adults, living alone and reporting disabilities and,

WHEREAS, it has become increasingly difficult to place this increasing population in adult care homes in the existing 432 adult care home beds in the county and,

WHEREAS, during the past twelve months, nineteen (19) senior residents of the City of Wilson Housing Authority alone have died or been forced into a nursing home prematurely due to the lack of affordable healthcare alternatives and,

WHEREAS, The Housing Authority of City of Wilson has conducted a market analysis demonstrating the acute demand for affordable adult care homes in the area, particularly among the special assistance clients and,

WHEREAS, The Department of Health and Human Services, through its Certificate of Need Law, has imposed a moratorium on the number of adult home care beds that can be created in Wilson County and,

WHEREAS, The Board of County Commissioners can request that a specified number of additional beds be licensed for development in their county under Chapter 131E of the North Carolina General Statutes in order to meet the needs of special assistance clients and,

WHEREAS, The City of Wilson Housing Authority will be the first public housing assisted living project, catering only to low-income seniors and disabled adults, already living in an existent public housing facility requiring no capital investment to convert to an adult care home and,

NOW, THEREFORE, BE IT RESOLVED the Wilson County Board of Commissioners requests the North Carolina Department of Health & Human Services to approve seventy (70) additional adult care home beds in Wilson County to enable The City of Wilson Housing Authority to allow its senior and disabled adults to age in place at a lower cost to the state and the county.

FURTHER BE IT RESOLVED that copies of this resolution are transmitted to the Department of Health and Human Services, Medical Facilities Planning Section.

Adopted this the 2nd day of April, 2007.

Frank Emory, Chairman
Wilson County Board of Commissioners

ATTEST:

Denise Stinagle
Clerk to the Board

Housing Authority of the City of Wilson, N.C.

August 8, 2007

Mr. Floyd Cogley, Medical Facilities Planning Section
Division of Facility Services
Dorothea Dix Hospital Campus
701 Barbour Drive
Raleigh, NC 27603

Dear Mr. Cogley:

Thanks for your call and request for additional information referenced in our petition.

Enclosed, please find the documents you requested. Additionally, I took the liberty to send you some information that may be helpful to you.

For clarification purposes, our request is for 58 beds rather than 70. Our apartment complex has 58 apartments as we had discussed.

If you need additional information, please let me know.

Sincerely,

Edward R. Jagnandan
Executive Director.

Enclosures

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

May 25, 2007

Mr. Edward Jagnandan
Executive Director
Wilson Housing Authority
POB 185
Wilson, NC 27894-0185

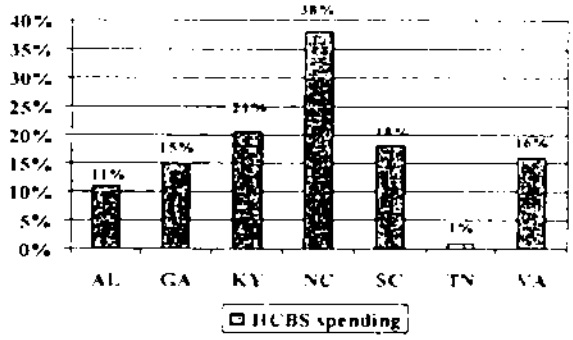
Dear Mr. Jagnandan:

On behalf of the Department of Health and Human Services, we appreciate your commitment to assisting the residents of your public housing facility, Tasman Towers, in their efforts to remain living as part of that community for as long as possible. We also appreciate the interests of your County Commissioners and Representative Farmer-Butterfield to support these efforts, and the offer of the Wilson County Department of Social Services (DSS) to work with you on any residents at risk of placement in an adult care home or nursing home.

We understand that the Wilson County DSS has made you aware of their many programs and services that might be of assistance to you and your residents. We also want to share with you some information about the roles that our respective divisions have in support of developing comprehensive local systems of supports and services for seniors and younger disabled adults. We believe that North Carolina has made some impressive strides toward offering home and community-based service options as depicted in the graphic below which is based on 2004 Medicaid spending.

States in the region

(Elders and adults with disabilities)



Location: 101 Blair Drive • Adams Building • Dorothea Dix Hospital Campus • Raleigh, N.C. 27603

The Divisions of Facility Services and Medicaid

The Division of Facility Services is responsible for the licensing and regulatory oversight of licensed and certified providers. The North Carolina legislature has defined several programs at General Statute 131D-2 to meet the needs of the elderly when they can no longer safely remain in their home and congregate living becomes necessary.

Room and board, personal care services (i.e., assistance with bathing, toileting, feeding, ambulation, and medication administration), and supervision are available in communal settings. The category which may most easily meet the efforts of the Wilson Housing Authority to quickly and successfully respond to your residents' needs as they age but don't require 24-hour supervision is the unlicensed category of the **multiunit assisted housing with services**. This program allows the residence, in this case the Wilson Housing Authority, to arrange for personal care, nursing, or hospice services. The housing management must have a financial interest, financial affiliation or formal written agreement which makes these services accessible and available through a licensed home care or hospice agency. The resident would individually contract with the licensed agency. The program is required to register with the Division of Facility Services and provide a disclosure statement regarding the program's features to the Division as well as to each of your residents.

The multiunit assisted housing program allows residents with varying needs and abilities to reside in their shared community receiving the services that meet their individual needs and ensures that as their needs change the services can be accessed in their home at the Tasman Towers. The benefits of this unlicensed status are significant. Unlike a licensed facility, it does not require all residents in the facility to have a defined level of need for services and would not result in discharge of those individuals who currently do not need personal care services. In other words, it allows aging-in-place. Additionally, it is does not require a certificate of need nor the building structure to meet licensure requirements.

The Housing Authority could, in addition to the room and board services they currently offer, choose to be licensed as a home care agency to provide services with the exception of in-home aide services currently under a moratorium for this service category. Licensing as a home care agency is also not regulated by certificate of need law and would allow, if interested, for Tasman Towers to develop that service just for the residents of the Towers Community or to the larger community in Wilson. During State Fiscal Year 2007, home care agencies were reimbursed for providing Personal Care Services to nine of the Medicaid recipients who used the Tasman Towers' address as their official address. Additionally two other Medicaid recipients were participants in the Community Alternatives Program for Disabled Adults (CAP/DA). CAP/DA is the State's Medicaid home and community care waiver program, which provides an alternative to placement in a nursing home.

Wilson County currently has 14 licensed adult care homes with 480 beds. Nine of these homes are licensed as family care homes, homes which provide services for two to six residents in a residential setting (and not regulated by certificate of need law), and five are licensed as adult care homes serving seven or more residents. The need for additional adult care home beds is determined annually by the North Carolina State Health Coordinating Council. Generally, need is based on a "deficit index" of 10% or greater and 85% or greater occupancy rate unless the deficit index is 50% or greater. The determination also looks at current bed utilization, a three-year projection of the age demographics of the county's residents, and the current inventory of beds. There was no indication of a need for additional adult care beds for Wilson County in 2007

based on the population projections for 2010. In fact, the projection indicates that there are excess beds within the county.

If Tasman Towers chose to pursue licensing as an adult care home, besides consideration of current certificate of need law, the building would be required, if licensed for the first time, to meet the North Carolina State Building Code for new construction (10ANCAC 13F.0302) including having a full sprinkler system. If interested in pursuing this licensure category, please contact the Wilson County DSS for assistance. The steps for licensing as an adult care home are detailed at http://facility-services.state.nc.us/floadult.htm. If Tasman Towers were to become fully licensed, the residents would be eligible to participate in the State/County Special Assistance program and your facility would be eligible to bill Medicaid for the Personal Care Services provided by your staff if qualified. Because the Medicaid Adult Care Home Services Clinical Policy is currently under a period of review and revision as mandated by the Center's for Medicaid and Medicare Services, some of the stated policy could be subject to change. Importantly, though, as Tasman Towers exists today—some of your residents might still be eligible for the State/County Special Assistance In-Home Option that is administered by the Wilson County DSS and is mentioned below in the section describing the Division of Aging and Adult Services.

Further information about the role of the Division of Facility Services can be found at these web addresses:

- Division homepage: http://facility-services.state.nc.us/.
- Acute and Home Care Section: http://facility-services.state.nc.us/hcpage.htm for licensing as a home care agency.
- Adult Care Licensure Section: http://facility-services.state.nc.us/enstpage.htm for licensing as an adult care home or information on registering as a multiunit housing program.
- Certificate of Need Section: http://facility-services.state.nc.us/conhpage.htm; and the Construction Section: http://facility-services.state.nc.us/enstpage.htm for licensing as an adult care home.

Division of Aging and Adult Services

The Division of Aging and Adult Services administers a number of home and community-based services and supports that might be relevant to your residents. The Division oversees all of the services that we understand were included in a list provided by the Wilson County DSS (e.g., in-home aide service, adult protective services, placement services). Working through the Wilson County DSS, the Division also administers the aforementioned Special Assistance In-Home Option for eligible persons. This represents a real alternative to placement in an adult care home.

The Division of Aging and Adult Services also administers the State's Home and Community Care Block Grant (HCCBG) through the Area Agency on Aging and a local lead planning agency, which is the Wilson County Manager's Office in your case. Your local HCCBG providers include the Wilson County DSS, the City of Wilson, the Wilson Office of Senior Citizens Affairs, Quality Patient Care, the Gee Corbett Center for Seniors, and the Wilson County Senior Center. While nearly 150 seniors in Wilson County are on the wait list for seniors (largely home-delivered meals), we do know that a few of your residents are receiving HCCBG services (e.g., transportation and congregate meals). The HCCBG services are especially focused on assisting the non-Medicaid socially and economically needy.

Further information about the role of the Division of Aging and Adult Services can be found at these web addresses:

- Division homepage: http://www.dhhs.state.nc.us/aging/
- County Services Fact Sheet (for HCCBG): http://www.ncdhhs.gov/aging/services/wilson.pdf
- Adult Services: http://www.ncdhhs.gov/aging/adultsvcs/adultsvc.htm

In addition to what we have described, other divisions within our Department, along with their local counterparts, may also be able to offer some assistance to you and your residents. These include the Divisions of Services for the Blind and Services for the Deaf and Hard of Hearing, and the Independent Living Unit of the Division of Vocational Rehabilitation. The 2007-2011 State Aging Services Plan has an inventory (Appendix A) that describes many of these programs and services (see http://www.ncdhhs.gov/aging/stplan/NC_Aging_Services_Plan_2007.pdf). The Department also has a web site on long-term services and supports that may be of some interest to you and provides contact information (see http://www.ncdhhs.gov/ltc/).

We hope this information is useful. Again, we commend your efforts to help your residents age in place. We feel certain that the Wilson County DSS and your other local partners will aid you toward this end through existing services and by collaborating to develop new approaches. If you have any questions, please feel free to contact us.

Sincerely,

Mark T. Benton

Mark Benton, Director
Division of Medical Assistance

Bob Fitzgerald, Director
Division of Facility Services

Dennis W. Streets

Dennis Streets, Director
Division of Aging and Adult Services

cc: Frank Emory, Chairman, Wilson County Commissioners (on behalf of/for all members of Board)
Ellis Williford, Wilson County Manager
Mayor Bruce Rose
Senator A. B. Swindell
Representative Joe Tolson
Representative Jean Farmer-Butterfield
Carmen Hooker-Odom, Secretary of NC Department of Health and Human Services

State of North Carolina
Talking Points

North Carolina ranks 10th in the number of persons 65 years and older with 969,048 individuals in this age group. This population is expected to increase by 129 % by year 2030 to a total number of 2.2 million or 17.8% of the population

In 2001, Medicaid spending for long term care totaled $2 billion an increase of 8.7% over previous year while the Medicaid eligible population grew by 16%. The state continues to increase support for community care and ranks 16th among all states in the percentage targeted to home care (37.3%, U.S. 29.5%). To control costs, the state regulates the development of adult care homes under the certificate of need and developed a state-wide inventory of adult care homes through its Medical Facilities Plan. In determining the demand for beds, the State only uses age instead of the criteria of number poor individuals, living alone, and suffering from multiple mobility and health issues.

There are five adult home care facilities in the County of Wilson for a total of 432 beds, some of which are earmarked for Medicaid eligible residents. The State will not approve new adult home care beds in Wilson County as they estimate that there is currently enough number of beds to cater to the growing population. There are over 10,000 seniors in need of assisted living services in the County. Within the existing facilities only residents who do not suffer from dementia and are mobile are considered for admission into the 160 square feet shared unit with no private bathrooms or kitchens. In the past, City of Wilson has not been able to place the increasing number of seniors and disabled adults and 9 have entered nursing home prematurely in the last twelve months. The rate for a private 100 square feet room is $4,000/month. This rate is beyond Wilson Housing Authority residents' income of $835/month.

City of Wilson Housing Authority will be the first authority in North Carolina to create a true-aging-in place project, catering to only low-income and severely disabled adults, by bringing services to residents already living in one of their high risers. Public housing facilities are debt free buildings, with private one bedroom units, private bathrooms and kitchens. No medical services will be provided with healthcare services contracted with existing healthcare providers. Other projects have produced a reduction in the number of hospital admissions, emergency room care and number of 911 calls. The buildings can be converted to adult home care with little or no capital investment. These units receive rental subsidies from USHUD. Public housing has the largest concentration of seniors and disabled adults in the country.

This unique project will prove the cost effectiveness of providing services to this often neglected population thus complying with the legislative intent of GS131D-4.1 of providing "quality of life and maximum flexibility in meeting individual needs and preserving individual autonomy." An exemption to the certificate of need is requested. The project will be evaluated at the end of five years by the Medical review committee charged with the study of problems among the aged and special assistant clients.

F-15

Dear Mr. Osborne;

Thank you for your letter of May 24th expressing your support in our mission to allow our public housing residents to age in place with dignity and avoid unnecessary and costly nursing home admission. For us it is a moral and compelling mission and we welcome the opportunity to join with partners such as your agency in achieving it. I also want to thank you for speaking with me over the phone regarding your letter and agreeing to meet with us again on June 1st.

Our concern deals mainly with the lack of understanding in what we are trying to achieve and what is required to do this. It is a very simple concept; just allow Wilson Housing Authority to obtain a license to provide the services for our seniors to remain in their homes. You state in your letter that services are already available and that there are 84 vacant beds in the County and yet the reality during the last twelve months alone is that we have been unsuccessful in placing an increasing number of our residents in the existing adult care homes. We have submitted the names of those unfortunate individuals. Not only has our staff worked diligently to place these and other residents in adult care homes, but a phone survey among all five homes in the area revealed that they only cater to residents who are mobile and need very little services.

We know that services exist and are supposed to be available to those in need; however, trying to obtain those services for our seniors and disabled adults has become a hardship. The existing facilities would rather cater to other type of residents. We wished the system will work as it should, but the reality is different.

We honestly do not understand the reaction from the State to refuse to try to understand this new and highly successful project that has been successfully implemented in other states and will accomplish the following:

- Has no fiscal impact to the State and will not require new administrative protocols or administrative staff to manage it.
- It will save the State and us the taxpayers about $30,000/resident/month for each resident that is kept away from a nursing home. In the case of Wilson Housing Authority it means a savings of $270,000 this year alone.
- Public housing facilities are federally subsidized and regulated, debt free and require few if any physical plant retrofits to become licensed.
- Public housing has the highest concentration of low income seniors and disabled adults living in the facility for an average of 15 years. They would like to age in place within their community and family/friends. This project will allow them to

continue to live there with dignity instead of moving to a home sharing a small room with a stranger and a bathroom for five other residents.

- Address the concerns of the State in finding an affordable, high quality, highly regulated housing provider to continue to care for the exponentially growing number of seniors and disabled adults.
- Allow the State to fully implement the Center for Medicaid/Medicare Real Choice Grant that was awarded a couple of years ago, but have not been fully implemented for lack of housing providers.
- Allow North Carolina to be ahead of the aging wave by establishing this model of housing with services that other states have and continue to implement in increasing numbers. We have enclosed a few housing authorities in different states that have implemented this type of service delivery with the blessing of the Legislature and with new funding appropriations.

It is in the face of all these arguments that we fail to understand your reticence in allowing us to move forward. The only obstacle standing in the way of us achieving all these benefits is to be exempted from the certificate of need (CON). We know that challenges to the CON are common and everyday occurrence and that there are great pressures for the state to revise the process as intended by the Legislature. Needless to say, the proposed project has been enthusiastically endorsed by residents, civic leaders, the media and local officials, which furthers confounds us in your inability to see the benefits it will bring to all of us.

Let me assure you that I will continue to advocate for this project and we hope that in so doing we can eventually count with your willingness to facilitate its implementation.

Sincerely yours,

Edward R. Jagnandan
Executive Director
Wilson Housing Authority

States that have recently implemented public housing demonstration projects:

Florida: Tampa Housing Authority, Miami Dade Housing Authority, Titusville Housing Authority, Pinellas County Housing Authority.

West Virginia: Huntsville Housing Authority, Moundsville Housing Authority, Williams Housing Authority and Wheeling Housing Authority.

Ohio: Wayne Metropolitan Housing Authority (six other housing authorities are in the process of obtaining licenses)

Tennessee: In the process of implementing the project. Four housing authorities interested.

Michigan: Legislation pending creating the demonstration project, 21 housing authorities interested, Grand Rapids, Belding, Lansing, and Madison interested in being the first ones.

California: In the process of implementing the project. Twelve housing authorities in the process of becoming providers.

New Jersey: Camden, Wildwood, Millville Housing Authorities

States that have Implemented Demonstration Projects in Public Housing

California: Created the first assisted living Medicaid waiver in conjunction with public housing authorities. In order to be eligible for Medicaid waiver reimbursement you must live in subsidized housing

Contact: Robert Jenkens Phone: 202 336-7653

Ohio: Created the first assisted living Medicaid waiver that includes a provision that residents must live in public housing.

Contact: Ronald Hornbostel Phone (614) 466-9927

West Virginia: Created first assisted living Medicaid waiver as a demonstration project in four housing authorities.

Contact: J. B. West Phone (304) 845-3141

Tennessee: Created a special reimbursement category for housing authorities that provided assisted living care.

Contact: Patricia Basham Phone: 931 473-3286

New Jersey: Created a licensing category for public/subsidized housing providers – Assisted Living Program, that requires no physical plant requirements. Reimbursement for services went up this year from $40 to $50/resident/day because of the success of the program in reducing Medicaid costs.

Contact: Alice Obelleiro Phone: 609 633-8270

Florida: Created first demonstration project in public housing in 1996. Given the success of one initial project, enacted legislation to give priority funding for Medicaid assisted living waivers to public housing providers. There are currently six housing authorities with assisted living programs.

Contact: Bob Lambert Phone 321 267-4204

Indiana: Created the first assisted living waiver with priority funding for housing authorities.

Contact: Beatriz Martinez Phone: 219 397-9974

Wisconsin: Governor created entitlement assisted living waivers throughout the state that involves public housing providers. The program was started as a demonstration project in four counties and given the success in cutting Medicaid cost it is now state-wide.

Contact: Wendy Fearnside Phone: 608 266-5456

We have pending legislation in Michigan, South Carolina, New York, and Texas to create demonstration projects in public housing. In addition, we are under contract with HUD in creating the national public housing demonstration project with funding from both HUD and the

Centers for Medicaid/Medicare. Three states have been identified, Arkansas, Wisconsin and Pennsylvania as pilot states.

Contact: David Fleischman Phone: 202 708-0614

There are other states that have implemented demonstration/new waiver programs in public housing, Minnesota, Colorado, Oregon & Washington State but our consultant have not been involved with them.

Feasibility Report Housing Authority of Wilson

Prepared By:

MIA Consulting Group, Inc

March 8, 2007

Table of Contents

I. Introduction

a. MIA Consulting Group, Inc.

MIA Consulting Group, Inc., was retained by the Wilson Housing Authority for technical assistance in performing due diligence with regard to the possible conversion of one of the authority's facilities into an adult care home. The scope of services included a study to determine the feasibility of providing assisted living services, market analysis, site approval, feasibility of contracting with third parties and outsourcing.

The consultants were also retained to provide the authority with expertise regarding the revenue sources available for the facility operation and advice on long-term care issues. The reason for the authority to request these services is the increasing number of frail elders and disabled adults living in public housing and their desire to provide this growing segment of public housing residents with alternative supporting services. Without these services, many residents have to move into nursing homes with a higher cost to the state Medicaid program. The authority is interested in allowing their frail elderly/disabled adult residents to remain at home with the appropriate services provided.

MIA Consulting has conducted considerable research in order to assess the need and demand for assisted living and the feasibility of the authority owning and operating an adult care home. MIA Consulting has concluded that there is a strong and growing demand for affordable assisted living services among the authority's elderly/disabled adult residents and in the larger community and that providing these services as described herein is feasible and cost effective.

b. Team Members

The following members will have sole responsibility for this project:

Conchy T. Bretos, Chief Executive Officer
Mrs. Bretos holds an MBA from Sydney Australia, a diploma in finance, and one year of graduate work in hospitality management. She attended the Harvard John F. Kennedy School of Management in 1989.

Mrs. Bretos served as the Florida Secretary for Aging and Adult Services in charge of all aging services including Medicaid, assisted living facilities, protective services and placement among others. She was a lobbyist and community organizer for AARP where she wrote several successful reform bills and served in the Healthcare Quality Assurance Taskforce and the Assisted Living Facility (ALF) committee.

She served on the Florida Commission on Long Term Care as a delegate for the White House Conference on Aging. She also served as a member of the Governor's Taskforce on the Prevention of Elder Abuse and was on the Board of the Area Agency on Aging and the Alzheimer's Association. She currently serves on several committees of housing, including the Florida Center for Housing & Long Term Care.

Mrs. Bretos was the Director of Housing for Florida International University (1984-1989) where she managed the construction and operation of the first student housing.

In 1977 she was the Program Director for the World Health Organization Southeast Region in Sydney and Chief Executive Officer of the College of Law (1981-84) also in Australia. Mrs. Bretos was the Director of Housing for Oberlin College (1975-77).

Pilar Bretos Carvajal, COO
Mrs. Carvajal holds a Master's degree from the London School of Economics and a Bachelors of Art from Smith College.

Mrs. Carvajal joined MIA Consulting Group, Inc. as an associate consultant in April of 2002. She has four years of experience in the field of affordable assisted living. She has specific experience in project management, financing, training and licensing processing and documentation. Mrs. Carvajal is licensed in Florida as an assisted living administrator.

Mrs. Carvajal has extensive experience as a management consultant with IBM Global Mergers and Acquisitions and Accenture. As such Mrs. Carvajal worked with numerous profit and non-profit corporations in the areas of organizational and performance competency, communications, productivity, marketing, information technology, and development of collaborative global initiatives.

Among Ms. Carvajal's major accomplishments has been the development, implementation, and institutionalization of new processes/methodology, assets, and tools in the areas of business transactions, innovative marketing, business development, human performance, performance management, staffing processes, communication strategies, among others.

II. Executive Summary

The aging of America phenomenon will double the number of seniors in less than forty years. This means that the growing demand for services among this population will continue to grow exponentially making it necessary for states to rethink the way it cares for the senior and disabled population.

North Carolina is no exception to this aging wave. The State is 10th in the nation in the number of seniors and will experience a significant growth within the next twenty years. Most dramatically, the population most at risk those 85 years and older is expected to increase by 42% between now and 2010.

Currently, 44,837 of the long term care senior population live in nursing homes or about 42% with 36% residing in adult care homes. This means that the State has made efforts to keep the senior population away from nursing home institutionalization in an effort to cut Medicaid spending. States like Oregon spend 29.5% in nursing home and 70.5% in community care. The cost of nursing home care is at least twice as expensive in North Carolina. Total Medicaid expenditures for older North Carolinians increased from $1.4 billion in 1999 to $1.7 billion in 2001, an increase of about 22% while the senior population grew by 16%. In 2002 Medicaid spending had decreased to $1.6 billion despite the growing numbers of frail seniors.

In other states, most residents of assisted living facilities pay a monthly fee that usually covers room and board and some basic services with other services priced separately. The typical base monthly fee ranges from $2,200 to $3,500 with additional services pushing the cost substantially higher. These fees make it unaffordable for low-income elders with an average monthly income of $600/month.

The number of adult home care beds available within the City of Wilson (302) is not sufficient to cater to the over 10,000 seniors and disabled adults that are living alone, under the poverty level and with

numerous mobility and health issues. A survey of existing adult home care facilities in the City shows that availability of Medicaid beds for those frail seniors and disabled adults is non existent. This has resulted in a large number of the authority frail and disabled population ending in nursing home prematurely or dying without the required services.

The Wilson Housing Authority manages three housing facilities designated elderly/disabled for a total of 381 units. There are 217 residents age 62 years and older living in three elderly facilities and 122 under the Section 8 program. The average age of these individuals is 76 years with 24 residents determined very low income (under $14,000/year) and 92 extremely low income (under 10,450/year). The average annual income of these elderly/disabled residents is $10,031/year. This means that most of the residents qualify for Medicaid waivers and a large number for the State Plan. Most of these residents have multiple health and disability issues.

MIA Consulting has conducted considerable research in order to assess the need and demand for assisted living within and outside the housing authority and to evaluate the feasibility of the PHA owning and/or operating a residential care facility. MIA Consulting has concluded that there is a strong and growing demand for affordable assisted living services among the authority's elderly/disabled residents and in the larger community and that providing these services as described herein is feasible and cost effective.

Elderly/disabled residents strongly agree that there is a growing need for assisted living despite the fact that most of them are receiving home and community care services. As a result of preliminary discussions with site staff, approximately 25 elderly/disabled residents at Wilson Housing Authority are currently needs-eligible for assisted living services and according to financial data, most if not all, of those residents are Medicaid eligible. Residents also reported that many of the current residents can use these services immediately.

The demand for these services will continue to increase exponentially as the number of elders/disabled adults grows over the next five years, with the increasing frailty among current residents and with the increased awareness among residents of the options that assisted living offers.

III. Market Conditions

The elderly population, persons 65 years or older, that comprised one in every twenty-five Americans in 1994 (3.1 million) numbered 34.5 million in 1999, and will more than double between now and the year 2050 to 80 million or one in five Americans. Today, they represent 12.7% of the US population, about one of every eight Americans. The older population will continue to grow significantly in the future. It is predicted to explode between the years 2010 and 2030 when the "baby boom" generation reaches age 65.

The oldest old, age 85 and over, represent the fastest growing elderly group in the U.S. In 2050, this group will grow to 19 million or 5% of all Americans. There will be about 70 million older persons in the year 2030, more than twice the number in 1999. Persons 65+ account for 12.7% of the population this year but are expected to grow to be 20% of the population in 2030. Most live alone are minorities with considerable mobility problems. In 1999 the U.S. median income of older persons was $19,079 for males and $10,943 for females. For all older persons reporting income in 1999, 34% reported less than 10,000. Only 25% reported incomes of $25,000 or over. It is estimated that in 1999, 3.2 million elders were below the poverty level.

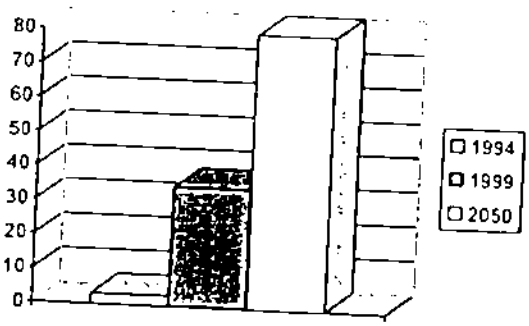


Figure 1: Elder population in 1994, 1999, and 2050 in the millions

Older women had the highest poverty rate. Public housing has the highest concentration of poor, frail elders in the nation, with over 1.6 million; vulnerable group, top heavy with the very old, women and minorities. USHUD is confronting a looming crisis with an exponentially growing frail, poor elder population without services or alternatives. At least 27% of elder public housing residents have a physical or mental disability. Most elderly poor live within public

housing with elder households occupying over 44% of the units in HUD assisted multifamily housing.

In the State of Florida alone 80,000 elders live in HUD subsidized rental housing. They are a vulnerable group, top heavy with the very old (over 80 years) women and minority. In 1999 Dr. Stephen Golant of the University of Florida released the CASERA project that documented the plight of elders living in public housing and called them the "largest numbers of concentrations of elder tenants." He called attention to this ignored group of residents that are not able to pay the $1,800/month market/semi private rate assisted living facility and must instead be unnecessarily institutionalized in nursing homes which cost the taxpayers four times more. Over 35% of housing elderly residents enter nursing homes when no longer able to live by themselves.

Dr. Golant makes a strong argument to provide the necessary, often few services, for these elders to remain in their homes. The reality is housing administrators report not having the knowledge, time or funding to be able to provide these services. On the other hand, state governments are anxious to reduce their Medicaid funding to nursing homes. For example, Florida Medicaid budget will hit $3billion in the next couple of years if the state is not able to divert more poor elders toward assisted living.

The reduced role of federal housing programs and the increasing demand on aging programs make it imperative to target older persons in need of assistance to live independently. Dr. Golant alludes to the changing philosophy of USHUD from one of a roof only to one of assisted housing. To quote a recent USHUD report "housing and services cannot longer be easily separated and, in fact, might be considered one and the same". In fact, over the past ten years state and federal programs have aimed at providing a wide array of services for elders, including those living in public housing.

North Carolina has a population of 8,683,242, an increase of 7% since 2000. Of this population, 74.1% is white, 21.8% Black and 6.4% Hispanic. The median income for the state is $39,438 with 13.46% of the population living below the poverty level. In 2005 individuals aged 65 years and older comprised 12.1% of the population. This population is expected to 13.3% by 2020 and to 20% by year 2030. Of this elderly population, 28.3% lives alone and a high percentage (25.1%) are considered disabled. In 2004, 20% of the elderly

population had incomes below $15,000/year. These three factors, low income, living alone with a disability indicate a high demand for affordable assisted living care in the state, a demand that will continue to grow exponentially as the population ages.

The state is making efforts to deter nursing home institutionalization by providing home and community services. The reimbursement rate for Medicaid nursing beds in North Carolina is about $100/resident/day compared to $45.86/resident/day in an assisted living facility. These efforts to reduce nursing home admission has resulted in considerable savings to the Long Term Care Medicaid budget. In 2006, the budget was $350 million under budget. In order to control costs and regulate the development of adult care homes, nursing homes and hospitals, the State instituted a certificate of need under which providers wanting to develop an adult care home have to apply for a certificate of need prior to obtaining a license.

There are 629 adult care homes in the state with a total of 35,247 beds. 24,000 Medicaid participants are receiving services in these facilities. The rest of the units are for private paid clients at a monthly rate of $3,000/resident for a private unit. In the County/City of Wilson there are five adult care homes for a total 432 beds. A telephone survey conducted among some of the state-wide facilities revealed that some cater to low-income residents but only in double occupancy units with no kitchens. The base rate in these facilities for a double occupancy is $2,600/month, more than the average income of public housing residents. Admission to these facilities is based on available slots. There are long waiting lists for low-income elders/disabled adults in all the facilities researched.

The County of Wilson has a population of 76,281, and increase of 3% since 2000. 58% of the population are White, 39.5% Black and 8% Hispanics. 13.1% of this population is 65 years and older with 16.7% under the poverty level. The per capita income for the county is $33,655

The City of Wilson has a population of 45,921, a 3.1% change since 2000. 46.7% of this population is white, 47.5% Black and 7.3% Hispanic. Individuals 65 years and over represent 13.5% of the population as compared with 12% state-wide. The percentage of individuals below the poverty level is 21.6% as compared to 12.3% nation wide, and the per capita income is $17,813, 14.7% live alone

and 37% reported a disability. The demographics for the City of Wilson denote a high demand for these types of services.

Within the Wilson Housing Authority there are 217 elderly and 164 disabled adult residents living in public housing and 119 disabled adults and 122 elderly under the Section 8 program. In the Forrest Road facility (Tasman Towers), there are 70 elderly residents and 61 disabled adults. The average income of the elderly residents is $10,031/year and thus will qualify for Medicaid waiver funding. The average age of the elderly residents is 76 years old with most suffering from major chronic diseases and debilitating conditions.

IV. Assisted Living in Subsidized Housing, North Carolina

a. Assisted Living Overview

The rapid growth of the assisted living industry is due to several factors including the growth of the population of older persons, the desire of disabled adults and elderly residents to remain in their homes and "age in place," the proximity of family support, and the dynamics of change within the cultural structure. In most states, policymakers are looking for ways to reconcile saving the state Medicaid budgets, and expand the population served by Medicaid at the same time.

There are several policy barriers, however, that affect the provision of assisted living services. One is the lack of a common definition of assisted living and the other is the fact that policy-makers are not well-educated about what assisted living is and how it fits in the long-term care continuum of care. This lack of understanding and sensitivity about the core features and the philosophy of assisted living coupled with the absence of a common policy definition of the product and a unified set of regulations that can be applied nation-wide, have resulted in overly stringent regulations in some states.

b. Senior Commission - The Commission on Affordable Housing & Health Facility Needs for Seniors in the 21st Century

The Commission on Affordable Housing & Health Facility Needs for Seniors in the 21st Century (the Senior Commission) was established by Congress in 1999 to study future housing and health facility needs for seniors and make specific policy and legislative recommendations to address the issues. The Seniors Commission has recently delivered its final report to Congress. The Commission used existing research

and specifically asked for additional research along with public and expert testimony in compiling the report.

The Commission describes what it calls the looming "quiet crisis" for seniors in America. The senior population of 65 or older is going to increase substantially and the anticipation is that many of these seniors will be living alone, isolated from services and coping with disabilities. The report finds that nearly 20 percent of seniors have significant long-term care needs. The greatest need is among the low-income elders. There are nearly six times as many seniors with unmet housing needs that are currently supplied by rental assistance, including public housing. One of the key concerns of the Commission was the linkage of shelter and services. The most urgent need was to provide housing and services to seniors with extremely low incomes, those incomes at or below 30% of area median.

In developing recommendations, the Commission adopted five guiding principles:

- Preserve the existing housing stock.
- Expand successful housing production, rental assistance programs, home and community-based services and supportive housing.
- Link shelter and services to promote and encourage aging in place.
- Reform existing Federal financing programs to maximize flexibility and increase housing production and health and service coverage.
- Create and explore new housing and service programs, models and demonstrations.

c. Proven Successful Model: Helen Sawyer Plaza ALF

A survey conducted by AARP in January 2002, among seventeen sponsors of subsidized housing providing assisted living services, revealed that assisted living could be successfully integrated into subsidized elderly housing projects. The major obstacles to implementing such projects are the funding for services and the training and coordination of housing and service staff. The research also revealed a variety of approaches in providing the needed services to their residents.

Among the sponsors were five housing authorities: Minneapolis, St. Paul, Vancouver, High Point-North Carolina, and Laconia in New Hampshire. Two of the housing authorities decided to provide the services directly while the other three contracted the services. Those providing services directly argued that doing this saved them money and gave them more control over the program.

This is the case of Helen Sawyer Plaza Assisted Living Facility is owned and implemented by Miami-Dade Housing Agency. This pioneer project has become the model for the nation and has generated new income and fifty new Section 3 positions. Those who contracted the services to outside agencies argued that they lacked the skills necessary to manage the program.

d. Elder/Disabled Services

Over the last ten years, state and federal programs have aimed at providing a wide array of services for elders/disabled adults, including those living in public housing. Homemaker services, home delivered meals, transportation, health screening, exercise classes and legal aid, among others, are available through the Area Agencies on Aging. Some of the programs offered through the North Carolina Department of Health and Human Services include the following:

- Case Management who assess elders needs and authorize the delivery of services based on a service plan and the level of need
- Personal care services include assistance with bathing and/or dressing, household chores, meal preparation and shopping
- Home delivery meals delivered once a day five days a week
- Adult Day Care services
- Health screenings and self-administration of medication management
- Structured social activities through senior centers
- Transportation to doctor appointments

These services are not sufficient to keep frail elders at home as they do not provide 24-hour supervision and are limited in time and scope. Providing this 24-hour per day supportive services by a licensed

operator are expensive and a dramatic departure from the management of independently living seniors. North Carolina has supplemented support to low income residents of adult care homes through State/County Special Assistance, which is an entitlement with payments being made directly to residents. Since 1996, Medicaid began covering enhanced personal care services for residents who need assistance with eating, toileting, ambulation/locomotion or any combination of the three. Revenue to pay for the cost of shelter and services can be expected to come from the following sources:

- USHUD public housing operating subsidies
- Elderly residents' rents at 30% of adjusted income
- Section 8 vouchers
- State/County Special Assistance and Medicaid enhanced personal care services
- Family contributions to the care of the elderly residents

Funding for new construction include the following:

- 501©(3) Tax-exempt bond financing issued by the housing authority's nonprofit affiliate
- Section 142 (d) Tax-exempt bond financing by housing finance authorities for both multifamily housing and assisted living. This funding is subject to the state tax-exempt bond volume cap and brings 4% federal low-income housing tax credits.
- Federal low income housing tax credits which are syndicated to raise equity
- State low-income housing tax credits, offered on a competitive basis
- Enterprise Community tax benefits, if the property happens to be located in an enterprise zone
- Taxable mortgage financing including bank loans and conventional debt

- Public housing comprehensive grant and modernization funds HOME, Community Development Block Grants, HOPE VI, NOFA and Super NOFA grants, and other funding avenues.
- North Carolina Housing & Community Development Authority affordable housing program
- Department of Agriculture Rural Housing & Economic Development (RHED) and Home Equity Programs.
- Home Choice Program by Fannie Mae
- Section 202 Supportive Housing for the Elderly
- Section 811 Supportive Housing for the Disabled
- Section 232 mortgage guarantee program
- Federal Home Loan Bank Affordable Housing Program

Public housing authorities have worked very hard to address the need for aging-in-place of their elderly residents. The vast majority of housing authorities have responded in the same way that Wilson Housing Authority has: assigning staff to coordinate local service programs, creating strong working relationships with social service agencies, and contracting with firms capable of implementing and managing assisted living services within existing or new construction buildings.

In 1999 USHUD funded the first new construction assisted living facilities through a targeted HOPE VI grants. Several housing facilities have successfully implemented assisted living services within their facilities by contracting with an assisted living operator. The success of these initiatives has depended largely on the availability of funding to pay for services as public housing can easily retrofit existing facilities that are owned with not debt service. The cost of privately owned assisted living is substantially higher because of the high cost of new construction.

Public housing facilities were designed for elderly residents and have been modernized to meet their needs and conform to state codes and regulations. In other words, it is much more economical to bring

services to these public housing seniors as they become frailer and is much less expensive to make the required physical improvements to existing building.

e. Definition of Assisted Living

There are about 29 definitions of assisted living with each state having its own regulations.

Assisted living in North Carolina is based on a home-like, rather than a medical model to provide housing for elders or disabled adults. Adult care homes provide personal care services (such as dressing and bathing,) 24-hour supervision, specific social activities, supervision of self-administered medication, administration of medication by qualified staff, three meals/two snacks per day or assistance with meal preparation, coordination of transportation, laundry and housekeeping services. At least one registered professional nurse must be available at all times (on call).

Under this licensing arrangement the provider must apply for an adult care home, in accordance with the provisions of 410 IAC 16.2. The residential care facility must provide or arrange for the provision of personal care, nursing, pharmaceutical, dietary and social work services. The provider must make available dining services to residents and have 24-hour staff supervision.

f. Certificate of Need:

The state does not allow the development new adult care home beds without first obtaining a certificate of need. The certificate of need was developed in response to legislation aimed at regulating the development of adult care homes, nursing homes, hospital and other long term care facilities. Prior to the enactment of legislation in 1997, the state imposed a moratorium on new adult care home beds. However, the legislation allowed for the development of additional beds under special circumstances defined as "exempt" if an explanation is provided of why these beds are needed in accordance with some criteria that include the elimination of imminent safety and health hazards and to provide non-health services.

Review of Senate bill 937 enacted in 2001 reveals that both nursing home and adult care homes were included in the existing certificate of need law to prevent underutilization of beds. The bill specifies that the

inclusion is temporary pending a better way of developing and maintaining the quality of adult care homes. If the vacancy rate of available adult care homes falls under 15%, then the Department will approve the creation of additional beds. In addition, the law allows for the Board of County Commissioners to determine that a need for additional beds exists particularly among the elderly/disabled adult population in that County. The law also exempts beds created within a continuum of care retirement community.

In order to determine the total inventory of adult care home beds and the need for additional beds, the state has developed an elaborate methodology based on the age of the population in that particular area, basically, the higher the age, the higher the use. Based on this methodology the state has determined that within the County of Wilson there is sufficient number of beds to cater to this old population. Wilson County is not included among the counties determined to have a need for additional beds. However, the 2007 inventory is subject to change based on whether or not the defined conditions have been met to allow for continued development of beds. Given that this will be the first public housing assisted living facility in the State involving a conversion of existing units with a limited capital investment, we recommend that a request to Wilson County Board of Commissioners be made to increase the number of beds. In addition, we also recommend that the Legislature creates a demonstration project involving housing authorities within the state wishing to implement assisted living facilities.

V. Sources of Revenue for the Wilson Housing Authority.

Entitlement Programs - Social Security (SS), Social Security Supplemental Income (SSI), Medicare, Medicaid, State/County Special Assistance, the Enhanced Personal Care (Medicaid), and Section 8-voucher assistance.

Most elderly/disabled adults living in subsidized housing in North Carolina subsist on entitlement programs such as social security, SSI and/or a small pension. They all benefit from Medicare, an age-driven entitlement program (65+) for the costs of medical care and some durable goods. Some of these elders are also eligible for Medicaid, an income-driven program for all persons who receive less than $1,163.50/month. Therefore, all persons over 65 years of age are entitled to Medicare, but not Medicaid unless their income is less than that stipulated.

The State of North Carolina provides funding for room and board and limited services to individuals residing in an adult care home who are recipients of the Medicaid or Social Security Income programs. The resident submits their social security check and receive a $46 personal need allowance.

a. Medicaid Waivers 1915(c) a/k/a
Home and Community-Based Services 1915(c)

Medicaid home and community-based service (HCBS) waivers afford the states the flexibility to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation. The HCBS waiver program recognizes that many individuals at risk of being placed in these facilities can be cared for in their homes and communities preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Under *Section 1915 (c) of the Social Security Act*, States may request waivers of certain Federal requirements in order to develop Medicaid-financed community-based treatment alternatives. The three requirements that may be waived are in Section 1902 of the Act and deal with state wideness, comparability of services and community income and resource rules for the medically needy.

The act specifically lists seven services that may be provided in HCBS waiver programs; case management, homemaker/home health aide services, personal care services, adult day care, re-habilitation, and respite care. Other services, requested by the states as needed by waiver participants to avoid institutionalization may also be provided, subject to Center for Medicaid (f/k/a Health Care Financing Administration) approval, but are beyond the scope of this discussion. Room and board is excluded from coverage except for certain limited circumstances.

States have the flexibility to design each waiver program and select the mix of waiver services that best meets the needs of the population they wish to serve. HCBS waiver service may be provided statewide or may be limited to specific geographic subdivisions.

Several states have created demonstration projects to determine the success of the ALF waiver in diverting residents from nursing home

admissions. For example, the State of Florida, through the legislature, has created specific appropriations for Medicaid qualified facilities coordinated through public housing programs and demonstration projects for assisted living for the elderly. This appropriation specifically allows public housing authorities that wish to create a licensed Assisted Living Facility to contract directly with the State Department of Elder Affairs for an allocation. The allocation is provided the facility on an annual basis, and is monitored through the local Area Agency.

HCBS waiver programs are initially approved for three years and may be renewed at five year intervals to the states. There are currently 240 HCBS waiver programs in effect. All States except Arizona have at least one such program. Arizona is a technical exception, though, because it runs the equivalent of an HCBS waiver program under Section 1115-demonstration waiver authority. In North Carolina, services in adult care homes are reimbursed as a state plan service through Medicaid for individuals aged 65 and older and working age adults with disabilities, mental retardation and other developmental disabilities.

The maximum State/County Special Assistance payment for room and board (the state SSI supplement) is $1,118/resident/month plus $46/month paid to the resident as a personal allowance. The Medicaid payment varies with the needs of the residents. The payment methodology was modified in January 2004. The payment includes a basic amount for personal care and the amount varies for small and large facilities from $16.74/day to $18.34/day for facilities with over 30 beds. In addition, an enhanced payment for residents requiring additional care with eating, toileting, ambulation and transportation of about $15/resident/day. In 2004 there were 24,000 participants being served under this program

In order to become a waiver provider, the facility must be licensed as an adult care home. Services to be provided include three meals/day, transportation, activities, housekeeping and personal care.

Room and board is reimbursed through the State/County Special Assistance payment for eligible residents who are 65 years and older or determined disabled, low income, and/or cannot live alone but do not qualify for nursing home care.

In 2004 there were 2,200 facilities participating in the state plan (Medicaid) servicing 24,000 residents. The following are assisted living settings licensed by the state:

Assisted Living Residences: These include any group housing and services program for two or more adults, which makes available, at a minimum, one meal per day, housekeeping services, and provides personal care services directly or through a formal written agreement with one or more licensed home care agencies. Settings in which the services are delivered may include self-contained apartment units or single or shared room units with private or area baths. There are three types of assisted living residences; adult care homes, group homes for developmentally disabled adults, and multiunit assisted housing with services.

Adult Care Home: These are a type of assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated trained staff. There are three types of adult care homes: Adult care homes licensed for seven or more beds; family care homes licensed for 2 – 6 beds; and group home licensed for up to nine developmentally disabled adults.

Multi-unit assisted housing with services: These are defined as "an assisted living residence" in which hands-on-personal care services and nursing services, which are arranged by housing management, are provided by a licensed home care or hospice agency through a written care plan. The resident has a choice of provider and the housing management may not combine charges for housing and personal care. Residents must not be in need of 24-hour supervision. No license is required, however, this type of facility must register with the Division of Facility Services and provide a disclosure statement.

b. US Department of Housing and Urban Development Subsidy for ACC Units

Operation Subsidy and Utility Subsidy for regular public housing ACC units is not to be commingled with the funds for services rendered in a public housing assisted living facility. Two ledgers are developed

separating what is essentially a normally operating cost center for the public housing authority from the operation of an assisted living facility.

Dwelling rents are determined according to standard HUD certification of income formulas utilizing only the SS or SSI. Costs including staff associated with each of the operations are divided accordingly. Some positions/costs may be prorated among the budgets.

Subsidy is determined according to the shortfall existing within the normal site cost-center operation. Operating and utility subsidy on PUM basis may be directed to cost center site budgets, as long as a Certificate of Occupancy has been issued and active marketing has begun.

c. Section 8 Assistance for Assisted Living Facilities

On September 1, 2000, the Department of Housing and Urban Development (HUD) issued Notice PIH 2000-41 implementing Section 523 of the "Preserving Affordable Housing for Senior Citizens and Families into the 21st Century Act" which confirms that a Public Housing Authority (PHA) may provide voucher assistance for families who live in an assisted living facility. These provisions were enacted in the Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act, 2000 (Public Law 106-74,113 Stat.1047, approved on October 20, 1999).

The intent of the vouchers is to allow frail elderly persons to live in an assisted living facility where they can obtain necessary supportive services to remain independent and avoid premature institutionalization. According to the notice, "a person residing in an assisted living unit must not require continual medical or nursing care. Nursing homes, board and care homes, or facilities providing continual psychiatric, medical, or nursing services, are not eligible properties under the housing choice voucher program." HUD may also develop additional guidance as issues arise and ALFs and PHAs gain experience in implementing this change.

Adapted from text of Conference Report for H.R. 2684, the VA-HUD and Independent Agencies for FY2000; as passed House October 13, 1999; enacted October 20, 1999 (PL106-74).

Sec. 523. Use of Section 8 Assistance for Assisted Living Facilities.

Voucher Assistance - Section 8(o) of the United States Housing Act of 1937 (42 U.S.C. 1437f(o)) is amended by adding at the end the following new paragraph: "(18) Rental assistance for assisted living facilities.-'"

In general - a public housing agency may make assistance payments on behalf of a family that uses an assisted living facility as a principal place of residence and that uses such supportive services made available in the facility as the agency may require. Such payments may be made only for covering costs of rental of the dwelling unit in the assisted living facility and not for covering any portion of the cost of residing in such facility that is attributable to service relating to assisted living.

Rent calculation-charges included - For assistance pursuant to this paragraph, the rent of the dwelling unit that is an assisted living facility with respect to which assistance payments are made shall include maintenance and management charges related to the dwelling unit and tenant-paid utilities. Such rent shall not include any charges attributable to services relating to assisting living.

Payment standard - In determining the monthly assistance that may be paid under this paragraph on behalf of any family residing in an assisted living facility, the public housing agency shall utilize the payment standard established under paragraph (1), for the market area in which the assisted living facility is located, for the applicable size dwelling unit.

Monthly assistance payment - The monthly assistance payment for a family assisted under this paragraph shall be determined in accordance with paragraph (2) (using the rent and payment standard for the dwelling unit as determined in accordance with this subsection).

Definition - For the purposes of this paragraph, the term "assisted living facility" has the meaning given that term in section 232(b) of the National Housing Act (12 U.S.C. 1715w(b)), except that such a facility may be contained within a portion of a larger multifamily housing project.

Project-Based Assistance - Section 202h of the Housing Act of 1959, as added by section 522 of this Act, is amended- (1) by redesignating

subsections (f) and (g) as subsections (g) and (h), respectively; and (2) by inserting after subsection (e) the following new subsection: (f) Section 8 Project-Based Assistance -

Eligibility - Notwithstanding any other provision of law, a multifamily project which includes one or more dwelling units that have been converted to assisted living facilities using grants made under this section shall be eligible for project-based assistance under section 8 of the United States Housing Act of 1937, in the same manner in which the project would be eligible for such assistance but for the assisted facilities in the project.

Calculation of rent - For assistance pursuant to this subsection, the maximum monthly rent of a dwelling unit that is in an assisted living facility with respect to which assistance payments are made shall not include charges attributable to services relating to assisted living.

In Site Based Section 8 developments, rent is set according to the FMRs. The resident portion of dwelling rents, again, is calculated according to the income (SS+SSI) certifications. The housing assistance payment is calculated the same way as the normal voucher subsidy calculation. The housing assistance payment is the lower of the gross rent (including the utility allowance for all tenant furnished utilities) minus the total tenant payment or the payment standard applicable to the family minus the total tenant payment.

Two ledgers are developed separating what is essentially a normally operating cost center for the public housing authority from the operation of an assisted living facility. The remaining revenue from entitlement programs is income to the Assisted Living facility operation. Costs including staff associated with each of the operations are divided accordingly. Some positions/costs may be prorated among the budgets.

The use of Section 8 Housing Choice Vouchers in Assisted Living Facilities is authorized under US Department of Housing and Urban Development Notice PIH 00 - 41, Issued September 1, 2000 to "supplement the Medicaid Home and Community Based Waiver Program under Section 1915(c) of the Social Security Act to pay for residential care. These waivers allow Medicaid-eligible individuals at risk of being placed in hospitals, nursing facilities, or intermediate care facilities the alternative of being cared for in their homes and communities. The use of housing choice vouchers in assisted living

facilities also allows the frail elderly to obtain supportive services in order to remain independent and avoid premature institutionalization." The key to the success of this, like the regular ACC public housing unit is to separate the operation account of the HUD cost center from the operation of the Assisted Living Facility.

VI. Residents - Assessment - Eligibility

In North Carolina, a resident must meet certain eligibility requirements to receive the State-County Special Assistance and Medicaid waiver services. Individuals must need adult care services, meet incomer eligibility requirements of no less than $1,163.50/month and less than $2,000 assets. To be eligible for the enhanced adult care home personal care program, residents must need assistance with eating, toileting and/or ambulation, be 65 years or over, or, in some counties, be 19 years old determined disabled by the Social Security Administration. They must also be assessed by their physicians as well as by the case manager from the Department of Social Services (DSS). The DSS case manager then completes an assessment and the authorization/care plan.

The assessment and care plans relate to a physical and psychological (functional) assessment that is performed initially and revalidated annually. The measurements used to qualify and quantify the pool of potential recipients are based on a system of "activities of daily living"(ADLs) and "incidental activities of daily living"(IADLS).

VII. Objectives of Feasibility Report

The objective of the report is to determine the feasibility of converting an existing public housing building into a licensed residential care facility, determining the target market and the financial feasibility and best use of the facility. In order to determine the feasibility, the following research was conducted.

Resident/Tenant and Staff: *Review of the authority's resident/tenant profile in general, level of frailty and need for assistance/services, security issues, and Medicaid eligibility.* Discussions with a large group of residents revealed support for bringing assisted living services to elderly and disabled adults in order for them to remain at home.

Discussions with staff were conducted to determine the need for

specific services to allow these public housing residents to age in place, satisfaction with their current accommodations and services, degree of frailty and ability to perform activities of daily living (ADL's). An evaluation of vacancies was done to determine the number of residents that have died and/or moved to more restrictive environment (nursing homes) when not able to live independently anymore).

Waiting Lists: There are 330 clients in the Wilson Housing Authority waiting list, with 37 elderly and 95 disabled adults. The average time on the waiting list is 18 months. The main reason for applicants to reject offers of a unit in one of the facilities is the lack of funds as SSA and SSI checks are received at the beginning of the month. During the past twelve months, nine residents have been transferred to nursing homes and eight have died.

Financial Analysis: Review of financial/operational statements that were provided to the housing authority to determine the financial viability of the prior operation versus an affordable model. The costs of any improvements including physical plant requirements were reviewed. Pro-forma was developed to determine the start-up costs of the operation and the long-term financial feasibility of the project.

Market Research: A review of the demographics in the state, the area of Wilson, availability of services and in particular the availability of other low-income residential care facilities, nature of competition and future demand projections.

Site: Tasman Towers, the only elderly/disabled designated high rise was inspected to identify ease of conversion to adult care home. Tasman Towers was considered the best candidate for conversion given the renovations that have been made to that building, the number of vacancies (16) and the number of residents eligible for services living in the building. The five-story high rise building has 58 one bedroom units, with a small kitchen, common areas, administrative offices carpeted lobby, one elevator, a conference room, two wheel-accessible bathrooms, and a laundry room on the first floor. There are six (6) wheel-chair accessible units. New air conditioners were installed in each unit in 1999. The lobby was carpeted three years ago, and new exterior doors were installed with a press access button. There are smoke detectors in all common areas and residents' units and a fire detection system monitored by Simplex and the local fire department. The facility is within 2 miles of a hospital, clinics,

community agencies including the Department of Social Services and a shopping mall. The facility is well served by public transportation with bus stops in front of the building.

Individual resident's units have private bathrooms and kitchens with wood kitchen cabinets, stove and refrigerators. All bathrooms have bathtubs with grab bars. The front doors of all units are at least 36" wide and are of 1.75 solid wood, self closing, and fire retardant doors. All other doors within the unit are at least 32" (813 m) in width. All units have tile floors and are individually air conditioned with cable and phone jacks and emergency call cords in both the bathrooms and the kitchens that trigger a light outside the unit door.

There are janitor locked closets on every floor. The building is located in the business area, close to amenities and services, including the Department of Social Services, a hospital, a shopping mall, clinics and local community agencies.

VIII. Findings:

There is a definite demand for assisted living services within the Wilson Housing Authority. There are not enough affordable adult care homes within the City or County of Wilson. There are only five adult care homes within the County with three within the City with a total of 302 beds. A phone survey among these facilities revealed that Medicaid clients are only accepted for double occupancy (common bathrooms) and if they are not frail. A private unit costs in the range of $3,000/month. Due to the area demographics, the projected increase in frail elders and disabled adults, and the lack of affordable residential care facilities, this demand is projected to increase exponentially within the next ten years.

The consultant met with several staff members and there was enthusiastic support for bringing assisted living services to the authority. According to staff there is an immediate need for assisted living services for at least 20 residents. With both elderly and disabled adults being served under the waiver, the staff felt confident that 50 residents would join the program by the end of the first year. Staff reported that an increasing number of older, frailer residents are being admitted to the facilities that are not able to live independently. These residents are offered limited personal care and services, but need 24-hour supervision, meals, and medication management to remain at

home. The staff currently coordinates services for residents with the Department of Social Services.

Tasman Towers is the only elderly/disabled designated building within the Authority. Most of the current residents are in need of services. We recommend that the entire building be licensed as an adult care home thus creating a true aging-in-place environment and avoiding relocation of residents. The following is a list of required services that must be provided in a residential care facility:

- Three meals per day, seven days a week and snacks. Special diets provided. (Schedule of meals posted)
- Housekeeping/laundry services
- 24-hour supervision by certified staff
- Personal care
- Supervision of self-administration/administration of medication
- Referral to other services, including home health nurse
- Limited nursing services
- At least 14 hours per week of activities
- Pharmaceutical services
- Arrangement of transportation for healthcare services

The building will require the rewiring of the personal alarm systems into a newly created staff station on the first floor, an expansion of the existing kitchen to accommodate a six burner stove, commercial dishwasher, three-sink compartment, a three door refrigerator/freezer, an ice maker, and microwaves. Storage for dry and emergency food will have to be provided within the existing janitor closet. Lighted exit signs must be provided on each of the exit doors and lever door knobs should replace all of the existing door knobs. A staff station will have to be provided on the first floor by converting one of the first floor units, with lockable storage for medications, a sink with a single hand motion lever, a shower for bathing residents, and two phone jacks. Grab bars must be installed on the right side of all corridors capable of supporting 250 pounds of concentrated load. One fire extinguisher must be provided for each 2,500 square feet of space and one five pound ABC or C0/2 type extinguisher in the kitchen and maintenance area. A signaling device on exit doors will have to be installed if the authority caters to dementia residents.

The need for a sprinkler system depends on the fire resistance construction of Tasman Towers. If the architect determines that the

building has been constructed of one-hour fire resistant materials, including the corridors, ceilings, walls, partitions and floors, there is no need to install a sprinkler system

Laundry facilities for the program will be provided from the existing laundry room. There are no additional physical plant requirements for the conversion.

Tasman Towers is well located, served by public transportation, and within short distance of shopping areas providing an array of services and activities to residents. The area is also served by one major hospital. This is important as the residents of the residential care facility must keep in touch with their community and receive the required health services promptly and effectively.

The project will be financially viable, eligible to receive Medicaid waiver funding, residential care assistance, enjoy full occupancy, provide an option for low income elder's residents of the authority, be consistent with the mission of the authority, improve residents' mental and physical conditions and increase their level of satisfaction.

IX. Description of Licensing Requirements:

Physical plant requirements for licensing adult care homes in North Carolina must meet the North Carolina State Building Code for I-2 Institutional Occupancy and meet local zoning requirements. The following are the physical plant requirements as identified in the North Carolina Administrative Code 13 F:

- Application for a license to operate an adult care home that will be retrofitted must include plans and specifications and a review fee.
- The building must meet the North Carolina State Building Code for I-2 Institutional Occupancy if the facility houses 13 or more residents.
- The sanitation, water supply, sewage, disposal and dietary facilities shall comply with the rules of the North Carolina Division of Environmental Health.
- Adult Care homes shall be in a location approved by local zoning boards.
- The site of the proposed facility must be approved by the Division of Facility Services prior to renovation and must be accessible by streets, roads, highways and be maintained for motor vehicles and emergency vehicle access.

- ☐ Water supply, sewage disposal system, garbage disposal and trash disposal must be approved by the local health department.
- ☐ Each living room/recreational area must be located off the lobby or corridor and 50% must be enclosed by doors and walls.
- ☐ In buildings licensed for 16 or more residents a minimum of 16 square feet per resident of living space.
- ☐ Living/recreational area must have windows.
- ☐ Dining room must be located off the lobby/corridor, enclosed with walls and doors and 14 square feet per resident for facilities licensed for 16+ residents.
- ☐ Bedrooms must be located off a corridor and must have a minimum of 100 square feet/resident or 80 square feet for double occupancy. Total number of residents assigned to a bedroom must not exceed two.
- ☐ Each bedroom must be ventilated with one or more windows equipped with insect screens, with a maximum of 36 inches high and with openings restricted to a six-inch opening.
- ☐ Bedroom closets must provide 48 cubic feet of clothing and have an adjustable hanging bar
- ☐ Bathrooms and toilet rooms must be accessible to the handicapped as required by Volume I-C, North Carolina State Building Code, Accessibility Code.
- ☐ Hand grips must be installed in all commodes, tubs and showers used by or accessible to residents.
- ☐ One bathroom opening off the corridor with a door of 3 feet minimum width, a three feet by three feet roll-in shower, a bathtub accessible on at least two sides, a lavatory and a toilet.
- ☐ Bathrooms and toilets must be well lighted and mechanically ventilated at two cubic feet per minute. Nonskid surfacing or strips must be installed in showers and bath areas and the floors must have water resistant covering.
- ☐ A minimum area of five square feet per licensed capacity must be provided for general storage.
- ☐ Linen storage must be adequate in size and number for separate storage of clean linen and soiled linens.
- ☐ Space must be provided for dry, refrigerated and frozen food items.

- ☐ One housekeeping closet, with mop sink or mop floor receptor must be provided for each 60 residents.
- ☐ Separate storage for storing cleaning agents, bleaches, pesticides and other hazardous materials.
- ☐ Hand wishing facilities with wrist type lever handles must be provided immediately adjacent to the drug storage area.
- ☐ Some means for residents to lock personal articles within the home.
- ☐ Some means for staff to lock personal articles within the home.
- ☐ Handrails must be provided on both sides of corridors at 36 inches above the floor and capable of supporting 250 pounds of concentrated load.
- ☐ Corridors must be lighted with night lights providing 1 foot-candle power at the floor.
- ☐ All steps, porches, stoops and ramps must have handrails.
- ☐ All exit door locks must be easily operable by a single hand motion from the inside at all times without keys.
- ☐ A sounding device must be installed if the facility has at least one resident who is determined by the physician to be disoriented.
- ☐ All floors shall be of a smooth, non-skid material and easy to clean.
- ☐ A separate room must be provided for the cleaning and sanitizing of bed pans with hand washing facilities. This requirement may be waived if all the units have private bathrooms.
- ☐ One residential type washer and dryer provided in a separate room accessible to staff, residents and family.
- ☐ Fire alarm system must be able to transmit the fire alarm signal automatically to the local emergency fire department dispatch center, pull stations within five feet of each exit, products of combustion (smoke) listed detectors in all corridors, heat detectors or products of combustion detectors in all storage room, kitchens, living rooms, dining rooms and laundries. Emergency power for the fire alarm system must have automatic start generator or trickle charge battery system for 24 hours. Emergency egress and exit lights powered from an automatic start generator or a U/L approved trickle charge battery system.
- ☐ For facilities not equipped with a complete automatic fire extinguishment system each bedroom must be provided with smoke detectors.

- ☐ Air conditioning or at least one fan per resident bedroom and living/dining area must be provided when the temperature in the main corridor exceeds 80m degrees.
- ☐ Hot water temperatures in all fixtures used by residents must be maintained at a minimum of 100 degrees F and not exceed 116 degrees F.
- ☐ Call systems connecting each resident to the staff near to the bedroom and bathroom.

X. Financial Analysis and Assumptions

Financial projections and a pro-forma were developed and are enclosed.

The financial pro-forma was developed with the following assumptions in mind. The facility would be operationally financed through the following revenue streams:

- Medicaid waiver State Plan
- State/County Special Assistance Program
- Private pay residents at $2,088/resident/month.
- Payroll costs are based on the statutory required client/staff ratio
- One full-time administrator
- Part-time activity director
- One full-time administrative assistant
- $1,000/month reserve for replacement
- $100/unit/ year of liability insurance
- Food preparation in house

The cost of conversion is not included in the pro forma but it is estimated to be under $200,000. We have requested from the architect a final cost estimate of the conversion costs. It is anticipated that funding for the conversion will come from reserves or from City/County grants.

Payroll costs are based on the statutory required client/staff ratio. Payroll costs are the highest expense in an assisted living facility followed by food costs. A management fee of 6% of total revenue has been included in case that the Authority decides to have an outside firm manage the operation.

Liability insurance for the residential care facility, a requirement for licensing, is currently very high given the incidence of lawsuits in nursing homes. For the purposes of this pro forma, we will budget liability insurance at the increased cost of $100/unit per year. This is realistic given the fact that it may be optional due to sovereign immunity for a local governmental authority.

XI. Staff Recommendations

Discussions with staff were conducted. They agreed that an increasing number of residents are in need additional services now like personal care, medical assistance, housekeeping/laundry, medication management, 24-hour supervision and transportation. They were enthusiastic about the possibility of 24 hour on site awake staff being available if services were to be provided by the Authority.

The group agreed on the following issues:

- Assisted living services were very much needed, particularly, personal care, medication management, and 24-hour supervision.
- Providing services to disabled adults will help alleviate some of the major problems faced by staff and residents.
- The facility is well equipped for conversion and the entire building should be licensed to avoid relocation.
- The residents would like to have the option of staying at home with the required services when too frail to live independently.

The staff feels that at least 25 residents would benefit today from these services. All of these residents are Medicaid eligible. Of the residents identified as needing assistance, most suffer from high blood pressure, diabetes, have ambulatory difficulties, and sight deficiencies. The staff felt that with 24-hour supervision, medication management and a proper diet, their mental and physical health will improve.

In the past twelve months, nine residents have been transferred to nursing homes and eight have died. The staff coordinates assisted living services with the local Social Service Department. Availability is restricted to the percentage of beds allocated to Medicaid eligible residents. Providing assisted living services would have prevented these residents from either dying or leaving the authority.

A meeting with a large group of residents revealed that most residents were supportive of bringing assisted living services to the authority

Residents want to be part of the planning of this project and the availability of temporary rehabilitative services. Some felt that they did not need the services at this time. However, other residents stated that they would take advantage of these services immediately.

XII. Recommendations:

We strongly recommend that The Wilson Housing Authority move forward in converting Tasman Towers as an adult care home to provide services to their frail elderly and disabled adult residents as well as to other clients in the County/City of Wilson area. Contrary to our findings, the State has determined that there are sufficient number of adult home care beds within Wilson County and will not accept applications for a certificate of need for new beds. The certificate of needs is a pre condition to obtaining an adult home care license. Thus we recommend that an exemption to the Certificate of Need be requested order to proceed to licensing. There are two ways we recommend that this be done. First a demonstration project can be requested through the Legislature. The law regulating the development of adult care homes also allows County Commissioners to request the addition of new beds if there exists a need for these beds. Our research has indicated that the demand for adult home care beds in the County and City of Wilson is greater than what is currently available.
The Authority Tasman Towers should be licensed entirely, thus providing a true aging-in-place program and avoiding relocation. However, the other elderly/disabled residents living in the facilities will be catered to by transferring these residents to Tasman. The high rise has been designated elderly/disabled only and assisted living services are being included in the Authority Master Plan.

There is a definite demand for assisted living services among the authority residents given the age and degree of frailty of most residents and the lack of affordable assisted living services in the area.

Tasman Towers will require the reconnection of the personal alarm systems, an expansion of the existing kitchen, installation of lighted exit lights, lever knobs, signaling mechanisms on exist doors, fire extinguishers throughout, grab bars on one side of corridors, creation of a staff station and an administrator office.

This project can become a catalyst in helping the authority deal with the mass longevity of its population while saving Medicaid budget

funds. Diverting authority residents away from nursing homes will result in considerable savings to the federal and state budgets.

This facility will cater to both Medicaid waiver eligible clientele, and also those "private pay" clients that do not meet the Medicaid income requirements of $1,163.50/month. The average age of the authority elderly residents is 76 years old with increasing incidence of impairment.

Interviews with staff of the Authority revealed that there is an enthusiastic support for a residential care facility within the authority. They feel confident that 25 current residents will join the program immediately with 25 additional residents joining the program within the first year. Authority residents were in full support of bringing these services to Tasman and felt that there is an increasing need among residents for assisted living services.

There is a great need for additional services/activities, particularly assistance with bathing, meal preparation, ambulating, 24-hour supervision, and supervision of medication, and transportation.

The demand for assisted housing for the elder/disabled public housing resident will continue to grow exponentially given the aging of the population in public housing, adjacent area, changes in the welfare system, medical advances in treating certain diseases as chronic rather than terminal, the lack of affordable assisted living facilities, and other factors.

The subject property is strategically located close to community and health agencies, thus enabling the authority to form natural partnerships for the delivery of needed services.

It is estimated that the cost of conversion will be about $200,000.00 The pro forma developed from the assumptions herein reveal an operational profit of $359,733.48 for the first year of operation. It is suggested that $136,063 be earmarked for budget shortfalls. In view that the facility is usually fully occupied we estimate that only 50 residents will receive services during the first year of operation. However, with only 50 residents it is estimated that during the second year of operation the operation will produce $523,004.80 in revenues over expenses.

XIII. Appendix A

MIA Consulting Group, Inc.
Request for Information from PHA
To Conduct Feasibility Study

- The total number of elderly residents (62+ years) living in public housing, with ages, income levels and if available any disability (e.g. wheel-chair, blindness etc.).
- The total number of elderly residents (62+ years) under the Section 8 program, with ages, income levels, and if available any disabilities.
- The number of residents on the waiting list for public housing, how long they have been on the waiting list, their average ages (e.g. of 250 in waiting list, 120 are 62 years and older).
- List the reasons why clients on the waiting list have been refused offers in the facilities.
- Number of vacancies during the past six months with reasons (e.g. died, left for health reasons, went to nursing home, etc.).
- A list of the services being provided by the PHA to residents, coordination of services (e.g. arranges for homemakers to how many residents), any information about level of frailty of these residents (do not include names just percentages – e.g. 10% suffer from dementia, 50% diabetic, blindness, etc.)
- Description of sites to be inspected (e.g. year built), how many floors, units, what kind of units (e.g. one-bedroom etc.), vacancy rates (e.g. two units vacant or 98% full), proximity to community agencies, hospitals, public transportation, shopping centers etc. If the building has been updated recently note when and what was done to it (optional). List any description of common areas (e.g. main floor has a community room with a large kitchen, laundry facilities). Describe the units (e.g. carpet, air conditioning, personal alarm systems, sprinklers, etc.).
- Prepare the financial information about the entire operation to determine any reserves for conversion, utility costs, USHUD subsidies, and liability insurance costs. Please note: this information does not have to be the actual financial statements but all the above information will be needed by the consultants prior to coming or during the meeting with director.

XIII. Appendix B

Bringing Assisted Living Services to Public Housing

These are services provided to frail residents of public housing who are at risk of entering a nursing home. These residents may be receiving homemaker services, but these are not enough to keep them at home. This is a totally voluntary program and only the residents who are assessed by their doctor and the state as needing these services are allowed to participate.

If provided within the facility, elderly frail residents wishing to receive the services will remain in their units with the additional services. Without these services these residents may be forced into a nursing home or a private ALF in the community.

Assisted living is based on a home model. It is **NOT** a nursing home but an alternative to a nursing home. It is **NOT** for independent residents. The facility remains under the ownership of the Authority and residents retain their public housing resident status.

What services are provided?

The main assisted living services are supervision and administration of medication by certified medication assistants, three meals a day, with special diets, arrangement for transportation to doctor's offices, housekeeping, laundry and assistance with activities of daily living (bathing, dressing, ambulating, transferring, feeding, and grooming) and nursing oversight. Room and board are not included. Services are reimbursed by Medicaid if eligible.

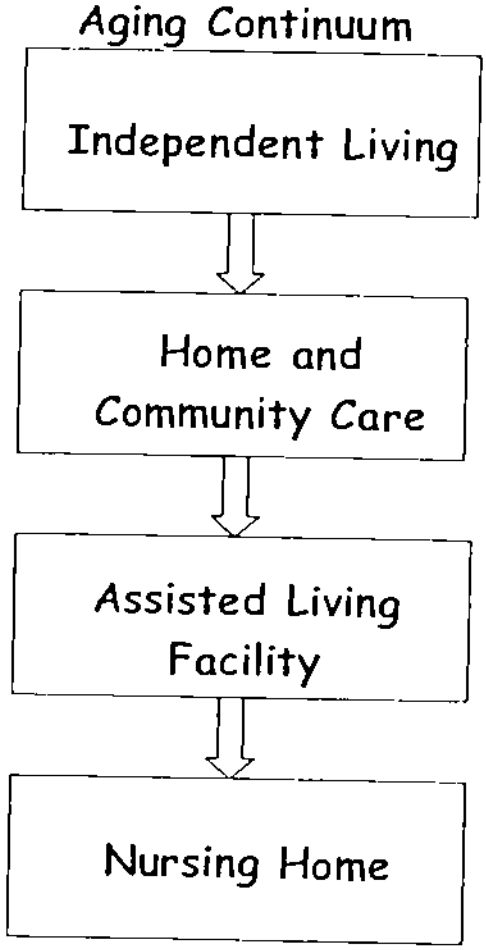
There are no doctors on the premises and residents retain their doctors. Medications are included for Medicaid eligible residents or the cost is billed to the resident's HMO/insurance. Residents can and do opt out of the assisted living program if their health improves and can function independently. Residents return to being public housing residents only.

What is the Cost?

There is no cost to the resident that is not part of the assisted living program. For residents who want assisted living services and on Medicaid, the services are covered by the Medicaid Program. They

still pay rent, utilities and meals and for residents who receive SSI, they retain $46/month from their social security check as a personal allowance.

For residents that want assisted living services but are non-Medicaid, they pay the facility. Their cost is $2,800/month. Additional services are available at an additional cost.



XIII. Appendix C

Residential Care Facility Questionnaire

1) Are you familiar with Residential Care Facilities?
2) Do you know of someone residing in a Residential Care Facility?
3) How many residents need these services in your building?
4) Can you think of anybody that could have stayed at home if these services were available?
5) Which services are most needed by the residents in your building?
    - 24 hour supervision
    - Supervision and administration of medication
    - Bathing
    - Toileting
    - Grooming
    - Ambulating
    - Dressing
    - Transferring
6) If you could not take care of yourself and had to go to a nursing home, would you like to have these assisted living facility services available to you as an alternative?
7) Would you give your social security check to pay for all of the services? If you could keep a small allowance for yourself?
8) Would you and your family be willing to pay for these services?
9) Do people in your building presently need help with the following:
    - Writing checks, paying bills, balancing the checkbook
    - Using the telephone
    - Physically moving around the apartment
    - Use one of the following to move around:
        - A person
        - Railing
        - Cane
        - Walker
        - Wheelchair
        - Combination/other
    - Grooming
    - Selecting clothes or getting dressed
    - Preparing balanced meals
    - Bathing
    - Using the bathroom when needed
    - Shopping and running errands
    - Doing laundry and personal housekeeping
    - Driving self or arranging to take the buses
    - Taking medications at the appropriate times of the day.

Petitions Inpatient Hospice 1 through 6
Received Regarding the Proposed 2008 State Medical Facilities Plan

Attached is the Agency Report on:

*Petition Inpatient Hospice – 1 from Hospice and Palliative Care Cleveland County
*Petition Inpatient Hospice – 2 from Hospice and Palliative Care Center (Forsyth County)
*Petition Inpatient Hospice – 3 from Hospice of Gaston County
*Petition Inpatient Hospice – 4 from Haywood Regional Medical Center Hospice
*Petition Inpatient Hospice – 5 from Johnston Memorial Hospital Authority
*Petition Inpatient Hospice – 6 from Angel Hospice and Palliative Care (Macon County)

NOTE: The Petitions and related comments follow:

Attachment – Hospice Inpatient 1: Petition Inpatient Hospice 1 from Hospice and Palliative Care Cleveland
Attachment – Hospice Inpatient 2: Hospice and Palliative Care Center (Forsyth County)
Attachment – Hospice Inpatient 3: Hospice of Gaston County
Attachment – Hospice Inpatient 4: Haywood Regional Medical Center Hospice
Attachment – Hospice Inpatient 5: Johnston Memorial Hospital Authority
Attachment – Hospice Inpatient 6: Angel Hospice and Palliative Care (Macon County)

AGENCY REPORT:

Proposed 2008 Plan

- Notes related to **Petition Inpatient Hospice-1** from **Hospice and Palliative Care Cleveland County**

- Notes related to **Petition Inpatient Hospice-2** from **Hospice and Palliative Care Center (Forsyth County)**

- Notes related to **Petition Inpatient Hospice-3** from **Hospice of Gaston County**

- Notes related to **Petition Inpatient Hospice-4** from **Haywood Regional Medical Center Hospice**

- Notes related to **Petition Inpatient Hospice-5** from **Johnston Memorial Hospital Authority**

- Notes related to **Petition Inpatient Hospice-6** from **Angel Hospice and Palliative Care (Macon County)**

REQUEST

Petition Inpatient Hospice-1: Hospice and Palliative Care Cleveland County submitted a petition for four additional hospice inpatient beds in Cleveland County.

Petition Inpatient Hospice-2: Hospice and Palliative Care Center submitted a petition for ten additional hospice inpatient beds in Forsyth County.

Petition Inpatient Hospice-3: Hospice of Gaston County submitted a petition to eliminate the need determination for seven additional inpatient hospice in Gaston County.

Petition Inpatient Hospice-4: Haywood Regional Medical Center Hospice submitted a petition for six hospice inpatient beds in Haywood County.

Petition Inpatient Hospice-5: Johnston Memorial Hospital Authority submitted a petition to reduce the need determination to four hospice inpatient beds rather than eight beds in Johnston County.

Petition Inpatient Hospice-6: Angel Hospice and Palliative Care submitted a petition for six hospice inpatient beds in Macon County.

BACKGROUND INFORMATION

The Proposed 2008 Plan makes single county determinations when the County deficit is 6 or more beds based on the Standard Methodology except for three counties (Columbus, Robeson and Surry) that have high days of care per 1000 population compared to the State average and also have a new hospice inpatient facility. Certificate of Need approved beds or need determinations in prior Plans. The hospice inpatient methodology bases total estimated inpatient days of care on 8% of total estimated days of care; projects inpatient beds based on

85% occupancy; and, adjusts projected beds for occupancy rates of existing facilities that are not at 85% occupancy.

Application of the methodology (excluding the three counties noted above) resulted in need determinations in 6 counties for a total of 43 beds.

Inventory Overview

There are 19 hospice inpatient facilities (155 beds) in the state. If all CON applications and need determinations through the Proposed 2008 Plan were to be approved, the state could have facilities in 43 counties with a total of 460 inpatient hospice beds.

The following table lists, based on the Proposed 2008 Plan, counties with inpatient and residential beds, number of beds, % of county and state deaths served by hospice, and hospice days of care per 1000 population for the county and state.

The table indicates that except for six counties, counties with inpatient and/or residential beds, have higher % of deaths served by Hospice than the state average. The table also indicates that about the same number of counties have higher hospice days of care as have lower days of care compared to the state average.

County/State	# Inpatient Beds	# Residential Beds	% of deaths served by Hospice	Hospice Days of Care per 1000
Alamance	6	6	35.76	236.38
Buncombe	15	12	32.15	236.27
Burke	0	6	33.72	329.68
Cabarrus	0	6	33.26	204.98
Caldwell	6	0	43.67	420.63
Catawba	5	10	47.51	336.98
Cleveland	5	9	38.7	342.2
Cumberland	8	0	25.63	449.25
Forsyth	20	10	35.42	192.46
Guilford	14	14	26.98	250.18
Harnett	7	0	30.76	609.54
Henderson	12	6	55.56	666.47
Iredell	3	6	29.64	218.94
Mecklenburg	8	0	32.9	171.74
New Hanover	12	0	41.65	243.69
Orange	6	0	29.82	154.35
Richmond	0	6	32.06	778.75
Robeson	12	0	26.11	1081.66
Rutherford	4	8	53.88	535.69
Scotland	0	6	50.4	622.52
Union	0	14	31.67	135.74
Wake	6	0	36.3	159.91
Wayne	6	6	26.18	306.75
State	155	125	30.46	280.66

In addition to licensed beds in existing facilities noted in the table above, several counties have beds that are CON approved and are yet to be licensed.

County/State	# Inpatient Beds	# Residential Beds	% of deaths served by Hospice	Hospice Days of Care per 1000
Beaufort	6	0	23.9	469.29
Burke	8	0	33.72	329.68
Cabarrus	6	0	33.26	204.98
Columbus	6	0	33.22	972.49
Davidson	8	4	27.07	210.17
Duplin	3	3	27.03	453.65
Durham	12	0	34.27	186.04
Gaston	6	6	34.24	245.75
Johnston	8	4	27.01	348.71
Mecklenburg	11	5	32.9	171.74
Moore	11	0	35.88	604.35
Pitt	8	0	27.98	235.26
Randolph	6	4	31.22	216.64
Robeson	6	0	26.11	1081.66
Rockingham	3	5	24.71	197.43
Surry	13	7	40.66	982.18
Union	6	6	31.67	135.74
Wake	8	6	36.3	159.91
Wayne	6	6	26.18	306.75
State	141	56	30.46	280.66

Further, as indicated in the following discussion regarding prior plan need determinations, several other counties that are not listed above may be approved to develop hospice inpatient beds in the future. They are: Alamance (2), Bladen (7), Brunswick (7), Caldwell (3), Catawba (6), Cumberland (21), Gaston (7), Harnett (9), Henderson (7), Iredell (6), Johnston (8), Lee (9), Lincoln (6), Nash (6), Richmond (9), Robeson (9), Rowan (7), Rutherford (6), Sampson (10), Scotland (4), Surry (7), and Wilson (8).

2002 Plan.

The 2002 Plan was the first Plan since 1995 to contain a need determination for inpatient hospice beds. The 1995 Plan identified a need for 14 inpatient beds in Forsyth County based on the standard methodology in effect at that time.

The 2002 Plan contained single county need determinations for five counties: Cleveland, Cumberland, Gaston, Richmond and Rutherford counties. The need determinations for Cleveland (two beds) and Rutherford (four beds) were based on adjusted need determinations recommended by the Long-Term Care Committee in response to petitions filed by hospice agencies in these counties. Both Cleveland and Rutherford counties exceeded the state average % deaths served by Hospice and Hospice days of care per 1000 population. Also, the number of beds requested by the petitioners agreed with the deficits identified in the 2002 Plan. The need determinations for Cumberland, Gaston and Richmond counties were based on the Standard Methodology. No CON applications were filed for the Gaston or Richmond need determinations identified in the 2002 Plan.

2003 Plan

The 2003 Plan contained single county need determinations for seven counties. The need determinations for Catawba, Forsyth, Iredell, Mecklenburg and Union counties were based on adjusted need determinations recommended by the Long-Term Care Committee in response to petitions filed by Hospices in these counties. The need determinations for Gaston (6 beds) and Richmond counties (9 beds) were based on the Standard Methodology. No CON applications were filed for the Richmond and Union County need determinations.

All counties (except Iredell) that received adjusted need determinations, exceeded the state average % deaths served by Hospice and two of the five counties exceeded the state average Hospice days of care per 1000 population. Also, with regard to Catawba and Iredell counties, the number of beds requested by the petitioners agreed with the deficits identified in the 2003 Plan. Union County requested four beds, but the adjustment was for 3 beds which was consistent with the deficit identified in the Plan.

With regard to Forsyth County, the committee recommended that the petition for 6 additional beds be approved even though there was a surplus of 2 beds based on the standard methodology. As noted in the Agency Report, the Forsyth County facility had a high utilization rate (approximately 97% occupancy). Also, the facility indicated a daily waiting list of 5-6 patients and that 3,312 inpatient days were denied due to lack of availability to inpatient beds in Forsyth County which would equate to 11.3 additional beds at 80% occupancy. It was also noted that the Forsyth facility served a larger area than just Forsyth County and there was support from the community, hospitals and physicians.

With regard to Mecklenburg County, the petition requested 21 inpatient beds. The eleven beds allocated by the committee was consistent with the standard methodology if the existing unit at Presbyterian Hospital had been at 80% occupancy.

2004 Plan

The 2004 Plan contained single county need determinations for seven counties. The need determinations for Duplin, Henderson and Surry counties were based on adjusted need determinations recommended by the Committee in response to petitions filed by Hospices in these counties. The need determinations for Guilford, Durham, Richmond and Robeson counties were based on the Standard Methodology. No CON applications were filed for the Durham, Richmond, or Robeson county need determinations.

Two of the three counties that received adjusted need determinations, exceeded the state average % deaths served by Hospice and the state average Hospice days of care per 1000 population. Also, with regard to Surry/Yadkin counties, the number of beds requested by the petitioner agreed with the deficits identified in the 2004 Plan.

With regard to Henderson County, the committee recommended that the petition for 6 additional beds be approved even though there was a surplus of 3 beds based on the standard methodology. The petitioner noted inpatient days had been constrained by the limitation on the number of beds (inpatient days decreased from 14.1% in 2000 to 11.8% in 2003). As noted in the Agency Report, the Henderson County facility had a high utilization rate

(approximately 91.5% occupancy). It was also noted that there was support from the hospital, physicians and other hospices.

With regard to Duplin County, the petitioner requested 3 inpatient beds. The committee recommended that there be an adjusted need determination for 3 beds even though the projected deficit was only one bed based on the standard methodology. The petitioner indicated issues related to distance from other inpatient hospice facilities, occasions when beds were not available, broad community support, and availability of funds for the project.

2005 Plan

The 2005 Plan contained single county need determinations for seven counties. The need determinations for Davidson, Pitt, Rockingham and Wake counties were based on adjusted need determinations recommended by the Committee in response to petitions. The need determinations for Cumberland, Harnett and Robeson counties were based on the Standard Methodology. No CON applications were filed for the Cumberland County need determination.

One of the four counties that received adjusted need determinations, exceeded the state average % deaths served by Hospice.

With regard to Pitt County, the committee recommended that the petition for 8 additional beds be approved even though there was a deficit of only 2 beds based on the standard methodology. The petitioner noted a sizeable number of hospital based deaths with diagnoses approved for admission to a hospice inpatient facility, a large service area, lack of inpatient hospice facilities, and the possibility of reducing the cost of care. The petitioner also provided evidence of broad community support and funds pledged for a facility.

With regard to Wake County, the petitioner requested 8 inpatient beds. The eight beds allocated by the committee was consistent with the standard methodology if the existing unit at Rex Hospital had been at 80% occupancy.

With regard to Davidson County, the petitioner requested an adjusted need determination for 6 beds. The committee recommended that there be an adjusted need determination for 4 beds which was consistent with the deficit identified based on the standard methodology. Noted was the level of support for inpatient beds in the County.

Regarding Rockingham County, the petitioner requested an adjusted need determination for 3 beds. The committee recommended that there be an adjusted need determination for 3 beds even though the projected deficit was only two beds based on the standard methodology. Noted was the level of support for inpatient beds in the County.

2006 Plan

The 2006 Plan contained single county need determinations for 18 counties. The need determinations for Davidson, Durham (the standard methodology indicated a need for 7 versus the 12 beds identified in the Plan), Macon and Wayne counties were based on adjusted need determinations recommended by the Committee in response to petitions. The need

determinations for the other counties were based on the Standard Methodology. No CON applications were filed for the Macon County need determination.

One of the four counties that received adjusted need determinations, exceeded the state average % deaths served by Hospice and the state average Hospice days of care per 1000 population.

With regard to Macon County, the committee recommended that the petition for 3 additional beds be approved. The closest facilities were in Buncombe and Henderson counties. Macon County had higher % of deaths served by Hospice and average days of care/1000 population than the State average. The petitioner provided evidence of community support and noted creation of a Foundation to provide financial support.

With regard to Durham County, the petitioner requested a total of 12 inpatient beds rather than the 7 bed need determination identified in the Plan. The Committee recommended approval of the petition. The petitioner provided evidence of community support. It was noted that Durham County had a relatively large population and was the site of an academic medical teaching center. Also noted was the collective projected inpatient beds for the triangle area was 36 while the total number of beds currently licensed or available for CON review was only 27.

With regard to Davidson County, the petitioner requested an adjusted need determination for four beds which was approved by the Committee and was consistent with the deficit identified based on the standard methodology. Noted was the level of support for inpatient beds in the County.

Regarding Wayne County, the petitioner requested an adjusted need determination for 6 beds. The committee recommended that there be an adjusted need determination for 6 beds even though there was a projected surplus of one bed based on the standard methodology. Noted was the high level of utilization of the existing facility and the level of support for additional inpatient beds in the County.

2007 Plan

The 2007 Plan contains single county need determinations for 9 counties. The need determinations for Alamance, Caldwell, Catawba, Iredell, Rutherford and Scotland counties were based on adjusted need determinations recommended by the Committee in response to petitions. The need determinations for the other counties were based on the Standard Methodology. The CON application deadline is September 15 for Catawba, Iredell and Rutherford counties.

Five of the six counties that received adjusted need determinations, exceeded the state average % deaths served by Hospice and four exceeded the state average Hospice days of care per 1000 population.

With regard to Alamance County, the petitioner requested an adjusted need determination for four additional beds. The committee recommended that there be an adjusted need

determination for 2 beds which was consistent with the deficit identified based on the standard methodology. Noted was the level of utilization of hospice services and support for additional beds.

With regard to Caldwell County, the petitioner requested an adjusted need determination for three additional beds which was approved by the Committee and was consistent with the deficit identified based on the standard methodology. Noted was the level of utilization of hospice services and support for additional beds.

With regard to Catawba County, the petitioner requested an adjusted need determination for six, or as an alternative, ten additional hospice inpatient beds. The Committee recommended approval of the petition for six beds. Noted was the level of utilization of hospice services and support for additional beds and the projected deficit of six beds.

With regard to Iredell County, the petitioner requested an adjusted need determination for six additional hospice inpatient beds. The Committee recommended approval of the petition for six beds. Noted was the level of support for additional beds. The plan projected a deficit of five beds.

With regard to Rutherford County, the petitioner requested an adjusted need determination for six additional hospice inpatient beds. The Committee recommended approval of the petition for six beds. Noted was the level of utilization of hospice services and support for additional beds. The plan projected a deficit of three beds.

Regarding Scotland County, the petitioner requested an adjusted need determination for four beds. The committee recommended that there be an adjusted need determination for four beds which was consistent with the deficit identified based on the standard methodology. Noted was the level of utilization of hospice services and the level of support for additional inpatient beds in the County.

Proposed 2008 Plan

The Proposed 2008 Plan identifies need determinations in six counties for a total of 43 beds. The counties are Brunswick, Gaston, Henderson, Johnston, Lincoln and Wilson.

Other

It should be noted that anyone may apply for the beds if it were decided to approve any of the petitions. CON applications could be submitted for a hospital based facility, nursing home based facility or a free-standing facility and the facility could be proposed for development anywhere within a county.

Staff provided copies of the petitions for comment to two organizations that represent hospice: Carolinas Center for Hospice and End of Life Care and the Association for Home and Hospice Care of North Carolina. No written comments were received from either organization as of the date this report was printed.

ANALYSIS OF INDIVIDUAL PETITIONS

Petition Inpatient Hospice-1: Hospice and Palliative Care Cleveland County
The petitioner requests an adjusted need determination for four additional hospice inpatient beds in Cleveland County. The petitioner currently has an inpatient facility, Wendover, in Cleveland County with 5 inpatient and 9 residential beds.

The Proposed 2008 Plan, page 283, identifies a deficit of "4" beds in Cleveland County, and, as a result, does not identify a need determination for new inpatient hospice beds.

Utilization of Existing Hospice Beds
The Cleveland inpatient facility reported 99.9% occupancy on the inpatient beds based on 2007 License Renewal Application information. The previous year the facility reported 100% occupancy. Cleveland County residents accounted for 75% of the days of care at the facility.

Two of the state's existing hospice inpatient facilities are in counties contiguous to Cleveland County; Catawba Valley Hospice House with a 5 bed facility in Catawba County, and Rutherford County's 4 bed Hospice Home facility. Based on 2007 License Renewal Application information, the Catawba facility did not report any days of care from Cleveland County and the Rutherford facility only reported 7 of the total 1,254 days of care from Cleveland County. One other facility reported days of care for Cleveland County, Presbyterian Hospital in Mecklenburg County reported 15 days of care. Based on reported utilization, it does not appear that the petition would have a significant impact on utilization of other facilities.

A Certificate of Need has been issued for the development of a new facility with eight inpatient beds in Burke County and Gaston County has been approved for a six bed facility. Based on the 2007 License Renewal Application for the Cleveland facility, 338 days of care of a total of 1,824 days was reported for Gaston County. Hospice and Palliative Care Cleveland County reported serving patients in Gaston County. Further, the 2007 Plan has a need determination for 6 inpatient beds in Rutherford County and the Proposed 2008 Plan has need determinations for 7 beds in Gaston County and 6 beds in Lincoln County. Based on the 2007 License Renewal Application for the Cleveland facility, no days of care were reported for Lincoln and Rutherford counties.

Other
As indicated in the Proposed 2008 Plan, Cleveland County was higher than the state average % of deaths served by Hospice and the state average days of care/1000 population.

The petitioner indicates a number of patients have not been served and an average of six patients were on the waiting list for admission. The county of residence for the patients is not identified. It is not known to what extent this situation may be addressed by the development of inpatient beds in contiguous counties.

The petitioner provided evidence of community support with numerous letters of support from a variety of sources representing health care providers in the area as well as comments from the public.

Agency Recommendation

The Agency supports the standard methodology. However, the Agency notes the level of utilization of hospice services in Cleveland County and the support for additional inpatient beds. The Agency recommends that the petition be approved for an adjusted need determination in Cleveland County for four inpatient hospice beds. Four beds is consistent with the deficit identified in the Proposed 2008 Plan.

Petition Inpatient Hospice-2: Hospice and Palliative Care Center (Forsyth County)

The petitioner requests an adjusted need determination for ten additional hospice inpatient beds in Forsyth County. The petitioner currently has an inpatient facility, Kate B. Reynolds Hospice House, in Forsyth County with 20 inpatient and 10 residential beds.

The Proposed 2008 Plan, page 283, identifies a surplus of "2" beds in Forsyth County and, as a result, does not identify a need determination for new inpatient hospice beds.

Utilization of Existing Hospice Beds

The Forsyth inpatient facility reported 100% occupancy for the inpatient beds based on 2007 License Renewal Application information. The previous year the facility reported 100% occupancy. Forsyth County residents accounted for 71.7% of the days of care at the facility.

Two of the state's existing hospice inpatient facilities are in a county contiguous to Forsyth County - Beacon Place with 8 beds and Hospice Home at High Point with 6 beds. Both facilities are in Guilford County. Beacon Place reported "0" days of care for Forsyth County and the facility in High Point did not report any days as it had not admitted any patients as of September 30, 2006 based on 2007 License Renewal Application information and no facility outside Forsyth County reported days of care for Forsyth County. Based on reported utilization, it does not appear that the Forsyth petition would have a significant impact on utilization of existing facilities.

Certificates of Need have been issued for the development of a new facility with eight inpatient beds in Davidson County, a three bed facility in Rockingham County and a 13 bed facility in Surry County. Based on the 2007 License Renewal Application for the Forsyth facility, of the total 7,541 days of care, 630 were from Davidson County, 29 were from Rockingham County and 253 were from Surry County. The petitioner reported serving patients in each of these counties. It is not known to what extent development of beds in these contiguous counties may effect utilization of the Forsyth facility.

Other

As indicated in the Proposed 2008 Plan, Forsyth County was higher than the state average % of deaths served by Hospice and lower than the state average days of care/1000 population.

It is interesting to note that if Forsyth County were at the state average days of care/1000 population, there would be a projected deficit of six beds rather than a projected surplus of 2 beds. Based on the days of care reported for the Forsyth facility on the 2007 License Renewal Application, there would need to be 24.3 beds in the Forsyth facility to have an 85% occupancy versus the reported 100+%.

The petitioner notes that 316 persons were not admitted in 2006 to the facility and 269 patients died waiting for a bed. Assuming that 65% of the persons not admitted were from Forsyth County and there was an 11 day average length of stay, there would be a need for approximately 7 additional beds.

The current inventory of licensed and CON approved beds in Forsyth and contiguous counties totals 58. In comparison, the total projected number of beds for these counties is 91. If Davidson, Guilford, Rockingham and Surry counties are subtracted, the total current inventory of licensed and CON approved beds would be 20 (the 20 beds in Forsyth County) and the number of projected beds would be 27 which results in a projected deficit of 7 beds.

As indicated in the background information provided at the beginning of this report, the Committee has recommended allocations of beds when there have been projected surpluses; namely, six beds for Forsyth in the 2003 Plan even with a 2 bed projected surplus and six beds for Henderson County with a projected surplus of 3 beds.

Letters of support were received from Hospice of Randolph County and Hospice of the Piedmont. A letter opposed to the petition was received from Mountain Area Hospice and Palliative Care.

The Agency notes that the petitioner's facility has 20 licensed inpatient beds. It is the largest hospice inpatient facility in the state. A question may be what would be the appropriate maximum size for an inpatient hospice facility? Also, what consideration should be given to geographic access within Forsyth County to inpatient hospice beds?

Agency Recommendation

The Agency supports the standard methodology. However, the Agency notes the level of utilization of hospice services in Forsyth County. Of particular note is that Forsyth County has the fourth highest population in the State and is the site of two regional tertiary care centers one of which is an academic medical teaching center. Both centers support the addition of inpatient beds. Further, if the Committee were to determine it was appropriate to consider the northern Piedmont as an area and the historical utilization of the Forsyth facility in the area, the Committee may consider it reasonable to grant the petitioner's request. If the Committee were to recommend approval of the petition, the Agency suggests that consideration be given to asking CON applicants to demonstrate consideration of facility size and geographic access to the medically underserved in their CON application.

Petition Inpatient Hospice-3: Hospice of Gaston County d/b/a Gaston Hospice

The Proposed 2008 Plan, page 290, identifies a need for 7 additional beds in Gaston County. The petitioner requests that the seven bed need determination for Gaston County be adjusted to a need determination of zero for the 2008 Plan (i.e., there would be no need determination in the Plan for additional hospice inpatient beds in Gaston County). The petitioner received a certificate of need for a facility in Gaston County with 6 inpatient and 6 residential beds.

Utilization of Existing Hospice Beds

The petitioner indicates the hospice facility opened in July 2007. No data was provided on utilization of the facility.

Two of the existing hospice inpatient facilities are in counties contiguous to Gaston County. The facility in Cleveland County, based on 2007 License Renewal Application information, reported a total of 338 days of care from Gaston County of a total of 1,824 days of care. Presbyterian Hospital in Mecklenburg County reported 116 days out of a total of 2215 for Gaston County. The facility in Caldwell County reported 5 days of care for Gaston County. It is also noted that a petition has been submitted to add beds in Cleveland County.

A certificate of need has been issued to develop a new 11 bed facility in Mecklenburg County and the Proposed 2008 Plan contains a need determination for 6 beds in Lincoln County.

Other

The petitioner references the plan methodology being incapable of determining the number of residential days versus inpatient days. The plan methodology does not address residential days nor does it attempt to project residential day utilization. The methodology projects days of inpatient care.

The petitioner notes that it makes more sense to allow the Gaston hospice facility to operate for a period of time and then determine whether additional inpatient beds are needed. However, it is quite possible that it could be 2010 or later before the additional 7 beds would be opened (assuming a certificate of need were applied for and awarded) based on the time table for development. For example, a need determination in the 2003 Plan lead to the development of the Gaston facility and the facility did not open until 2007. If there were to be a need determination in the 2008 Plan, the CON review could be scheduled to begin on December 1, 2008, and if the decision took 150 days and if no one appealed the decision, a Certificate of Need could be issued around May 2009. If new construction were to be involved, the facility may not be operational until 2010. Therefore, the existing Gaston facility could have operated for approximately three years before additional beds were licensed in the county.

The petitioner notes the adjustments made to exclude need determinations for Columbus, Robeson and Surry Counties. However, while it is true that Gaston has a new facility, Gaston has very different days of care/1000. Columbus, Robeson and Surry counties had days of care/1000 that exceeded the state average by over 300%. By comparison, Gaston's days of care/1000 is lower than the state average, 245.75 versus 280.66.

As indicated in the Proposed 2008 Plan, Gaston County was higher than the state average % of deaths served by Hospice.

Agency Recommendation

The Agency supports the standard methodology and is reluctant to recommend elimination of a need determination based on the standard methodology. Therefore, the Agency recommends that the petition be denied.

Petition Inpatient Hospice-4: Home Care Services of Haywood Regional Medical Center
The petitioner requests an adjusted need determination for six hospice inpatient beds in Haywood County. There is no hospice inpatient facility in Haywood County.

The Proposed 2008 Plan, page 284, identifies a deficit of "3" beds in Haywood County and, as a result, does not identify a need determination for new inpatient hospice beds.

Utilization of Existing Hospice Beds
Two of the state's existing hospice inpatient facilities are in counties contiguous to Haywood County; Solace in Buncombe County with 15 inpatient beds and Four Seasons' 12 bed facility in Henderson County. Based on 2007 License Renewal Application information, the Buncombe facility reported 220 days of care of a total of 5575 days from Haywood County and the Henderson facility reported "0" days for Haywood County. The Buncombe facility reported over 100% occupancy last year. Based on reported utilization, it does not appear that the petition would have a significant impact on utilization of existing facilities.

The Proposed 2008 Plan contains a need determination for 7 beds additional beds in Henderson County.

Other
As indicated in the Proposed 2008 Plan, Haywood County was lower than the state average % of deaths served by Hospice and state average days of care/1000 population.

As indicated in the background information provided at the beginning of this report, the Committee has recommended allocations of less than 6 beds and has recommended as few as 3 beds for counties.

Agency Recommendation: The Agency supports the standard methodology. However, the Agency recommends that the petition be approved to the extent that there be an adjusted need determination for Haywood County in the 2008 Plan. The number of beds identified could be as few as three which is consistent with the deficit identified in the Proposed 2008 Plan or as high as six as requested by the petitioner.

Petition Inpatient Hospice-5: Johnston Memorial Hospital Authority
The petitioner requests an adjusted need determination for four additional hospice inpatient beds in Johnston County rather than eight beds. The Proposed 2008 Plan has a need determination for eight additional beds in the county. The petitioner currently has a certificate of need to develop 8 inpatient and 4 residential hospice beds.

Utilization of Existing Hospice Beds
Three of the state's existing hospice inpatient facilities are in counties contiguous to Johnston County; Community Hospice House in Harnett with 7 beds, Rex Hospital in Wake with 6 beds and Kitty Askins Hospice Center in Wayne with 6 beds. Based on 2007 License Renewal Application information, Rex Hospital reported only 65 days of care of a total of 1547 for Johnston County and Kitty Askins reported 215 days of 2181. No other facility reported days of care for Johnston County.

The 2007 Plan has a need determination for 6 beds in Nash County. Further, Certificates of Need have been awarded for development of 8 additional beds in Wake County and 6 additional beds in Wayne County.

Other
As indicated in the Proposed 2008 Plan, Johnston County was lower than the state average % of deaths served by Hospice and higher than the state average days of care/1000 population.

The petitioner proposes that the need determination for Johnston County is overstated. As noted above, Johnston County has higher days of care per thousand (348.71) than the state average (280.66). If the number of inpatient beds projected for Johnston County were based on the State average, there would be a projected deficit of 5 beds (280.66 * 176642/1000 * .08)/365/.85 = 12.78. 12.78 – 8 CON approved beds = 4.78 bed deficit.) rather than the 8 bed deficit projected in the Proposed 2008 Plan.

Agency Recommendation: The Agency supports the standard methodology. However, the Agency notes the higher days of care/1000 population for Johnston County compared to the State average and the CON issued for 8 beds in Johnston County. Therefore, the Agency recommends that petition be approved and that there be a need determination for 4 beds in the Proposed 2008 Plan for Johnston County. As an alternative, the Committee may wish to recommend that there be a need determination for five beds based on utilization of the State average days of care per thousand.

Petition Inpatient Hospice-6: Angel Hospice and Palliative Care
The petitioner requests an adjusted need determination for six hospice inpatient beds in Macon County. There is no licensed hospice inpatient or residential facility in Macon County.

The Proposed 2008 Plan, page 284, identifies a deficit of "4" beds in Macon County and, as a result, does not identify a need determination for new inpatient hospice beds in the County.

Utilization of Existing Hospice Beds
None of the existing hospice inpatient facilities are in counties contiguous to Macon County and there are no need determinations in the Proposed 2008 Plan for Macon or contiguous counties. Two existing facilities reported days of inpatient care for Macon and contiguous counties. Solace in Buncombe County reported 29 days for Jackson County and 29 days for Macon County and Kirkwood in Caldwell County reported 8 days for Swain County.

Other
As indicated in the Proposed 2008 Plan, Macon County was slightly lower than the state average % of deaths served by Hospice and higher than the state average days of care/1000 population.

The petitioner notes the combined contiguous county deficits for a six county area in the far western portion of the State in which there are no inpatient hospice beds. Based on the Proposed 2008 Plan, the combined deficit within Cherokee, Clay, Graham, Jackson, Macon and Swain counties is "8" with "4" of the "8" being for Macon County and "2" of the "8" being for Jackson County. Based on 2007 License Renewal Application information, within

Macon County, Angel Hospice and Palliative Care provided the majority of hospice care. This is also true of Swain and Graham counties. WestCare Home Health and Hospice, which is located in Jackson County, provided a letter of support for the petition. WestCare provided the majority of care in Jackson County and also provided services in Macon, Swain and Graham Counties.

The petitioner provided evidence of support with numerous letters of support from citizens, clergy, a physician and WestCare. The petitioner also noted donations being received.

Agency Recommendation: The Agency supports the standard methodology. However, the Agency notes the level of utilization of hospice services in Macon County and the support for inpatient beds. The Agency recommends that the petition be approved and that there be an adjusted need determination in Macon County for six inpatient hospice beds.

Petition Inpatient Hospice – 1
Received Regarding Proposed 2008 State Medical Facilities Plan

Petition from Hospice and Palliative Care Cleveland County. (note: included with the letters of support submitted with the petition are comments from the Charlotte public hearing.)

PETITION

Petition for a Special Need Adjustment to the Hospice Inpatient Bed Need Methodology

Petitioner:

Hospice & Palliative Care Cleveland County
951 Wendover Heights Drive
Shelby, NC 28150

Myra McGinnis, Executive Director
(704) 487-4677

Requested Change:

Hospice & Palliative Care Cleveland County requests an adjusted need determination for four hospice inpatient beds in Cleveland County.

Reasons for Requested Change:

Hospice & Palliative Care Cleveland County owns and operates Wendover *The Kathleen Dover Hamrick Hospice House*, a combined inpatient and residential hospice facility with five inpatient beds and nine residential beds. According to Table 13C in the Proposed 2008 State Medical Facilities Plan (SMFP), Hospice & Palliative Care Cleveland County's five inpatient beds were the third most utilized hospice inpatient beds in North Carolina, operating at 99.9 percent occupancy in FY 2006. The Proposed 2008 SMFP also indicates a projected need for a total of nine hospice inpatient beds in Cleveland County, leaving a deficit of four beds.

Under the current methodology, there is no mechanism for allocating additional hospice inpatient beds in Cleveland County until a deficit of six beds is reached. Hospice & Palliative Care Cleveland County is requesting an adjustment to the standard need methodology to allocate the four additional inpatient hospice beds that are identified as needed in the Proposed 2008 SMFP.

Without the proposed adjustment, Hospice & Palliative Care Cleveland County will be forced to:

1) Continue to operate at or near 100 percent occupancy,
2) Deny admission to our facility to patients in need of our specialized services due to the lack of available beds,
3) Require patients to remain on a waiting list for admission to the facility, creating additional stress and potentially negatively impacting their health care and quality of life.

As noted previously in the petition, Hospice & Palliative Care Cleveland County's existing five inpatient beds operated at almost 100 percent occupancy in 2006. For 2007 year-to-date, the occupancy for these beds equals 100 percent. Occupancy exceeded 100 percent in 2005 and exceeded 97 percent in 2004.

During 2006, a total of 58 patients were on the waiting list for admission, but were never admitted because no bed was available. All of these patients died somewhere other than our hospice inpatient facility. The number of patients not able to be served through June 2007 has already reached 32. A random sampling of days throughout the year in 2006 and year-to-date in 2007 indicates that on any given day, an average of six patients were on the waiting list for admission to the facility. The addition of four inpatient beds would significantly reduce the number of patients on the waiting list and the number denied admission to the facility.

As noted in the letters of support attached to this petition, hospice inpatient care is an important component in the continuum of care in Cleveland County. Hospice & Palliative Care Cleveland County, along with Cleveland Regional Medical Center, Cleveland Home Health Agency, Cleveland Pines Nursing Center, CLECO Primary Care Network, Kings Mountain Hospital, and Crawley Memorial Hospital, are members of the HealthCare Enterprise. The strategy of the HealthCare Enterprise includes assuring that community health care resources are used with maximum stewardship, that duplication of health care effort is minimized, that missing components of the health care service continuum are identified and targeted, and that the health delivery continuum is as seamless and accessible as possible. Each of these providers is strongly committed to honoring the continuum of care and referring patients to the most appropriate level of care available in our community. This cooperative spirit among the providers has led, in part, to the success of our hospice inpatient facility and its recognition as the standard for end-of-life care in Cleveland County. As such, we strongly believe there is no other appropriate alternative to meet the needs of such patients other than to add more hospice inpatient beds.

While we agree that six beds may be a reasonable threshold for the establishment of a new hospice inpatient facility, we believe it is unreasonable to force an existing provider, operating at near 100 percent capacity and turning away patients, to wait until a deficit of six beds is established before allocating additional beds that are so clearly needed. We would also note that our existing inpatient facility has been a feasible and financially viable operation for over ten years and our organization has over 20 years of service within our county.

For these reasons, we are respectfully requesting an adjusted need determination for four additional hospice inpatient beds in Cleveland County.

CLEVELAND COUNTY
PRIMARY CARE
NETWORK

July 24, 2007

Dr. Dan Myers, Chairperson
North Carolina State Health Coordinating Council
Medical Facilities Planning Section
Division of Facility Services
2717 Mail Service Center
Raleigh, NC 27699-2714

Dear Dr. Dan Myers,

I am writing to you in support for Certificate of Need for Hospice & Palliative Care of Cleveland County. Hospice of Cleveland County is wonderful and I do not know what the county would do without Hospice. They have been in business since 1985 and still growing because the need is so great here. When you have a loved one that is terminal it means so much to have Hospice of Cleveland County. The patients and families have a place to go and be together as well as getting great care and feel they are loved and being cared for. Sometimes they must turn patients away due to the bed situation. They serve all surrounding hospitals and nursing homes in the Cleveland County and take patients regardless of the ability to pay. The need is so great and we would really appreciate all you could do to help Hospice of Cleveland County and the citizens of Cleveland County with the Certificate of Need for more beds.

Thank you very much.

Wendy Gunter
Operations Manager
CLECO Primary Care Network

101 East Grover Street • Shelby, North Carolina 28150 • Telephone (704) 484-3647 • Fax (704) 471-2727

CMG-FAMILY MEDICINE OF CLEVELAND COUNTY
807-3 Schenck Street, Shelby, NC 28150
Phone: (704) 480-0222, Fax: (704) 480-6007

Lynda Lachance, MD *Brad Gardner, C-NP*

July 24, 2007

Dr. Dan A. Myers, Chairperson
North Carolina State Health Coordinating Council
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Dear Dr. Myers:

This letter is to express our support for the expansion of our current Hospice and Palliative care facility in Cleveland County.

I have had the privilege to serve on the board of Hospice & Palliative Care Cleveland County and know how well run and how appreciated this service is in our community and surrounding counties.

This organization has been providing end of life services in Cleveland County since 1985 and has provided inpatient services since 1996 at Wendover.

Wendover underwent a needed expansion in 2004 increasing its capacity for inpatient care to 5 beds and residential beds to 9. However even with this great addition, the demand for inpatient care is not met and every day deserving patients and their exhausted families are turned away.

In 2006- the waiting list for a bed averaged six patients a day and 58 patients were turned away during that year. So far as of June 2007, Hospice turned away 32 patients.

The greatest asset to Hospice is their wonderful team approach creating an intimate collaboration with most institutions in Cleveland county including: Cleveland Regional Medical Center, Kings Mountain Hospital, several nursing homes, Cleveland Home Health Agency and physicians' offices.

Hospice & Palliative Care Cleveland County serves all patients without regard to referral source or their financial status.

We would therefore welcome the addition of at least four more beds to the Wendover facility to better serve Cleveland County.

Sincerely,

Lynda Lachance, MD

CLEVELAND
PINES
NURSING CENTER

July 24, 2007
Dr. Dan A. Myers, Chairperson
NC State Health Coordinating Council
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

To Whom It May Concern:

Hospice & Palliative Care Cleveland County has been offering end of life services in Cleveland County since 1985 and has provided hospice inpatient services since 1996 at Wendover -- The Kathleen Dover Hamrick Hospice House; we currently have five inpatient beds and nine residential beds;

Hospice & Palliative Care is a partner in the HealthCare Enterprise, a unique collaboration which also includes Cleveland Regional Medical Center, Kings Mountain Hospital, Crawley Memorial Hospital, Cleveland Pines Nursing Center, Cleveland Home Health Agency and the CLECO Primary Care Network. This group works together in assure patients needing health services are seen at the appropriate place along the continuum of care;

Our current waiting list on any given day averages about six patients, more than enough to fill all four beds the SMFP says will be needed for Cleveland County in 2008;

Hospice & Palliative Care expanded Wendover in 2004 due to high occupancy levels and the fact that many potential patients were on a waiting list for Wendover at the time they died;

Through June of 2007, we have had to turn away, and have been unable to service at Wendover, some 32 patients and we project by year end this will reach well over 60 patients;

In 2006, our waiting list averaged about six patients a day and we turned away 58 patients;

We currently provide services to approximately 40% of all people who die in Cleveland County and are well respected by area providers and the community at large and Hospice & Palliative Care Cleveland County serves all patients without regard to financial or any other status.

Sincerely,

Charlotte Young

Charlotte Young, NHA
Cleveland Pines Nursing Center

Joint Commission
on Accreditation of Healthcare Organizations

1404 NORTH LAFAYETTE STREET • SHELBY, NC 28150
(704) 480-0128

Kings Mountain Hospital

Carolinas HealthCare System

July 31, 2007

Dr. Dan A. Myers, Chairman
North Carolina State Health Coordinating Council
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Dear Dr. Myers:

I am writing this letter in support of Hospice & Palliative Care Cleveland County's request to add four hospice inpatient beds in Cleveland County.

Hospice & Palliative Care Cleveland County owns and operates Wendover – *The Kathleen Dover Hamrick Hospice House*, which currently has five inpatient beds and nine residential beds. Occupancy at Wendover consistently approaches or exceeds 100 percent. In addition, Wendover maintains a waiting list and many patients are denied admission as a result of the limited number of beds.

Kings Mountain Hospital works closely with Hospice & Palliative Care Cleveland County through the Cleveland County HealthCare Enterprise, a unique collaboration that also includes Cleveland Regional Medical Center, Cleveland Home Health Agency, CLECO, Cleveland Pines Nursing Center, and Crawley Memorial Hospital. We work together to assure that patients receive appropriate services along the healthcare continuum.

Hospice & Palliative Care is highly respected within our community and is recognized as the primary provider of end of life care. The addition of four hospice inpatient beds will assist them in meeting the needs of patients throughout our community, and we therefore strongly support their request.

Sincerely,

Sheri DeShazo
COO, CNE

706 West King Street • Kings Mountain, NC 28086 • 704-739-3601 • 704-739-0800 (fax)

TIMOTHY E. CLONINGER, M.D.
ROBERT W. FRASER, III, M.D., F.A.C.R.
MARK KIRSCH, M.D., F.A.C.R.
STEVEN R. PLUNKETT, M.D.
MARK J. LIANG, M.D.
JOHN B. KONEFAL, M.D.
MICHAEL R. HAAKE, M.D.
DONNA J. GIRARD, M.D.
CATHY H. SEYMORE, M.D.
L. SCOTT MCGINNIS, III, M.D.

SERO
SOUTHEAST RADIATION ONCOLOGY GROUP, P.A.
200 Queens Road, Suite 400 • Charlotte, N.C. 28204
Phone (704) 333-7376 • Fax (704) 333-7386 • www.treatcancer.com

CHARLES J. MEAKIN, III, M.D.
BRADLEY T. MCCALL, M.D.
YVONNE MACK, M.D.
THOMAS G. TRAUTMANN, M.D.
SCOTT P. LANKFORD, M.D.
BERNARD V. EDEN, M.D.
ROBERT M. DOLINE, M.D.
STUART H. BURRI, M.D.
ARTHUR W. CHANEY, III, M.D.

Paul A. Williams, M.S.P.H.
Administrator

July 24, 2007

Dr. Dan A. Myers, Chairperson
North Carolina State Health Coordinating Council
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

Dear Dr. Myers:

I am writing in support of the "Special Need" petition asking the state to allow four additional hospice inpatient beds in Cleveland County to be made available in 2008.

The State of North Carolina has determined that four additional inpatient hospice beds will be needed in Cleveland County in 2008. However, the Proposed 2008 State Medical Facilities Plan only authorizes construction when the need reaches six beds. I am requesting an allowance from the state to make the four beds available to Hospice and Palliative Care of Cleveland County in 2008 so that they can apply for a Certificate of Need during 2008 to obtain approval to build them.

Hospice and Palliative Care of Cleveland County has been offering outpatient hospice care in Cleveland County since 1985 and inpatient care since 1996. The inpatient facility was expanded to 5 inpatient beds and 9 residential beds in 2004 due to increased need and increased waiting time for bed availability. From January 2006 through June of 2007 there have been approximately six patients on the daily inpatient waiting list with nearly 100% occupancy of the five inpatient beds in 2007.

As a physician treating oncology patients in Cleveland County, I recognize the need for additional inpatient hospice beds and fully support the proposed petition. Hospice and Palliative Care of Cleveland County has provided an invaluable service to my patients and the community and the need for quality hospice care continues to increase. I appreciate the opportunity to write to you regarding the need for additional hospice inpatient beds in Cleveland County. I am certain that my patients, as well as others in Cleveland County, would benefit from this project.

Sincerely,

Helen R. Maddux, MD

Helen R. Maddux, M. D.
Radiation Oncology/Southeast Radiation Oncology Group
Cleveland Regional Medical Center

Cleveland County HealthCare System

Carolinas HealthCare System

July 25, 2007

DFS Health Planning
RECEIVED

AUG 0 1 2007

Medical Facilities
Planning Section

Hospice & Palliative Care
Cleveland County
951 Wendover Heights Dr
Shelby, NC 28150

To Whom It May Concern:

I am asking you to take a few minutes of your time to review my letter as part of the petition for "Special Needs" from Hospice & Palliative Care Cleveland County.

Hospice & Palliative Care of Cleveland County has been offering end of life services to the Cleveland County since 1985 and also has provided hospice inpatients services and care since 1996 at Wendover, the Kathleen Dover Hamrick Hospice House. They currently have 5 inpatient beds and 9 residential beds. Hospice and Palliative Care expanded Wendover in 2004 due to their high occupancy levels, and that many potential patients were on a waiting list for Wendover at the time they died. Their current waiting list averages about 6 patients a day, more than enough to fill all 4 of the beds that the SMFP says will be needed for the year of 2008 in Cleveland County.

Through June 2007, they have turned away and been unable to serve some 32 patients at Wendover. They project by the end of the year 2007 this will reach at least 60 patients. In 2006, their waiting list averaged about six patients a day; and for the year ended up turning away 58 patients. Their censuses for the existing 5 inpatients beds has been running at or close to 100% occupancy for 2007, and exceed 97% for both 2006 and 2005. Currently Hospice & Palliative Care Cleveland County provides services to approximately 40% of all people who die in Cleveland County. And they serve all of their patients without regard to status, including financial. With this being said, it is should be clear that they have the demand to fill the beds identified in this plan.

Hospice and Palliative Care are well respected by area providers and the community at large. They are a partner in the Healthcare Enterprise, a unique collaboration which also includes Cleveland Regional Medical Center, Kings Mountain Hospital, Crawley Memorial Hospital, Cleveland Pines Nursing Home, Cleveland Home Health Agency and CLECO Primary Care Network. This group works together to assure patients needing the health services are seen at the appropriate place along with the continuum of care.

I would like to thank you for your time. If you have any questions you may call my office at 704-487-3751.

Sincerely,

Peter Fortkort, MD
Regional Health Services

Cleveland County HealthCare System

Carolinas HealthCare System

John Young, President/CEO
Cleveland Regional Medical Center
Kings Mountain Hospital

July 24, 2007

Dr. Dan A. Myers, Chairperson
North Carolina State Health Coordinating Council
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Dear Dr. Myers:

It is with great pleasure that I write this letter in support of the pursuit of Hospice & Palliative Care Cleveland County to add four hospice inpatient beds in Cleveland County. Cleveland County Health Care System works closely with Hospice & Palliative Care Cleveland County and wholeheartedly supports their efforts to obtain additional inpatient beds in Cleveland County.

Hospice & Palliative Care Cleveland County has been offering their services in Cleveland County since the mid 1980s and inpatient services since 1996 at Wendover –*The Kathleen Dover Hamrick Hospice House*. This facility has five inpatient beds and nine residential beds, but still had to deny admission to 58 patients in 2006. Current census for the existing five inpatient beds has been running at or close to 100% occupancy for 2007 and exceeded 97% for both 2006 and 2005 so it is clear they have the demand to fill the beds identified in the plan. They provide services to approximately 40% of all people who die in Cleveland County. Area providers and the community at large highly respect the services they provide.

Hospice & Palliative Care Cleveland County is a partner in the HealthCare Enterprise, a unique collaboration which also includes Cleveland Regional Medical Center, Kings Mountain Hospital, Crawley Memorial Hospital, Cleveland Pines Nursing Center, Cleveland Home Health Agency and the CLECO Primary Care Network. This group works together to assure patients needing health services are seen at the appropriate place along the continuum of care.

With a Wendover waiting list averaging six patients a day, the addition of these inpatient beds will allow Hospice & Palliative Care Cleveland County to better serve patients in need. Therefore, I highly support their request to add four hospice inpatient beds in Cleveland County.

Sincerely,

John E. Young
President and CEO

704-476-7402 - CRMC
704-730-5400 - KMH
704-476-7406 - Fax
201 East Grover Street • Shelby, NC 28150
john.young@carolinashealthcare.org

Shem K. Blackley, III, MD
Michael Brame, MD

Cleveland Urologic Surgery, PA

Robert P. Gossett, MD

Providing Complete Urologic Care for Men, Women and Children

July 20, 2007

Dr. Dan A. Myers, Chairperson
North Carolina State Health Coordinating Council
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, N.C. 27699-2714

Dear Dr. Meyers:

Since 1982, I have been a practicing physician in Cleveland County, North Carolina and have served Hospice & Palliative Care Cleveland County in many capacities since its inception in 1985. Currently I serve as a board member and I am obviously very concerned about the future of this organization and its ability to provide this community with an appropriate level and quality of service. I am asking your support for a "Special Need" petition to allow us to go forward with a CON application for the 4 beds that the state of North Carolina has determined will be needed in this county in 2008.

Those of us who live in this community are aware of the commitment and positive impact this organization has made to Cleveland County and the surrounding area. Our citizens are also becoming increasingly aware of how difficult it is to obtain admission to our inpatient facility. We simply do not have enough beds (currently 14 beds -- 5 inpatient and 9 residential) as evidenced by our 100% occupancy and the fact that we have been required to turn away 58 patients last year and 32 patients so far this year. Some of these were my patients, and I have personally witnessed and shared the anguish experienced by these individual patients and their families.

As you are probably aware, our complete range of services are made available to all citizens regardless of their ability to pay. Perhaps this helps explain why so many who donate to our local United Way designate gifts to this organization. It is one of the big reasons I am proud to be a member of this community. I ask for your help to help us continue to meet the needs and expectations of our citizenry.

Thank you for your consideration. I have complete confidence in the ability of our Executive Director, Myra McGinnis to elaborate on these facts. I am of course available to address any specific questions you may have about the issues I have put forth. You can reach me through my office or if you prefer my cell phone number is 704 418-2892.

Respectfully,

Robert P. Gossett M.D.

cc: Myra McGinnis

Cleveland Home Health Agency, Inc.

105 T.R. Harris Drive
Shelby, North Carolina 28150

Telephone (704) 487-5225
Admin. Fax (704) 484-9101
Clinical Fax (704) 484-9164

July 20, 2007

Dr. Dan A. Myers, Chairperson
North Carolina State Health Coordinating Council
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Dear Dr. Myers:

This letter is written in strong support for the Special Need Petition to the State of North Carolina for the Hospice and Palliative Care Cleveland County. As a non-profit provider I can attest to the mission of Hospice & Palliative Care for providing services to Cleveland County patients without regard to financial or any other status. Hospice & Palliative Care Cleveland County has been offering end of life services since 1996 at Wendover. They expanded in 2004 due to high occupancy levels and the fact that many potential patients were on the waiting list at time of death. They had to turn away 58 patients in 2006 and since 2007 they have already had to turn away an additional 32 patients and it's only July. Hospice & Palliative Care currently provides services to approximately 40% of all people who die in Cleveland County. The consistent quality of healthcare that Wendover has provided to Cleveland County is also our mission. By approving this request for expansion they will be able to continue an excellent level of service in the community. Currently Hospice & Palliative Care is a partner is a unique collaboration with also includes Cleveland Home Health Agency, Cleveland Regional Medical Center, Kings Mountain Hospital, Crawley Memorial Hospital, Cleveland Pines Nursing Center, and CLECO Primary Care Network. We work together to assure patients needing health services are seen at the appropriate place along the continuum of care.

Cleveland Home Health Agency, Inc.

105 T.R. Harris Drive
Shelby, North Carolina 28150

Telephone (704) 487-5225
Admin. Fax (704) 484-9101
Clinical Fax (704) 484-9164

This proposal targets critical needs in our county: the nursing facility shortage, the need to facilitate patients and quality initiatives in our agencies. This proposal will allow a more than qualified facility who desires are to serve the community, the opportunity to attain appropriate reimbursement. Additionally, they will have the availability to provide services to hospice patients awaiting placement at their facility.

Again, I strongly support this Special Need Petition.

Sincerely,

Pete Moore
C.E.O. Cleveland Home Health Agency
105 T R Harris Drive
Shelby North Carolina 28150
704-484-4408
www.clevelandhomehealth.org

HTMH Consulting

July 22, 2007

Dr. Dan A. Myers, Chairperson
North Carolina State Health Coordinating Council
Medical Facilities Planning Section,
Division of Facility Services
2714 Mail Service Center, Raleigh, NC 27699-2714

Dear Dr. Myers:

I am writing you in support of the Special Needs Petition that Hospice and palliative Care Cleveland County is submitting regarding hospice inpatient bed needs for Cleveland County. Having worked in healthcare most of my adult life, I am very familiar with health planning efforts in North Carolina. In terms of health service need determinations, I have found that the State Health Plan and the State Facilities Medical Plan generally do a very good job of determining what is needed and where. And when the needs change, the plan changes, though, due to the nature of the planning process, this takes a bit of time.

Since coming to Cleveland County in 1983, I have been aware of Hospice as it began its services on an outpatient basis in the mid 1980's; I was privileged to serve on its initial Board of Directors. I later came back to serve on the Board, at a time when it was envisioning its inpatient and residential facility. Through my former role of Executive Vice president of the Cleveland County Health Care System, I was able to continue my affiliation with the organization through an unique collaborative effort called the Health Care Enterprise. In all of my roles of working for and with Hospice, I have found them to be a deeply caring, high quality and forward thinking organization.

As you know, the SMFP Draft for 2008 shows a hospice inpatient bed deficit for Cleveland County of four (4) beds; the county currently has five (5) inpatient and (9) residential beds, all of which are at Hospice and Palliative Care Cleveland County's "Wendover" facility. The facility began its inpatient operations in 1996 and was able to expand its bed capacity in 2004. The average census of these beds, particularly the inpatient beds, has always been strong and has been near or at 100% for the past three years.

I understand that normally, hospice inpatient beds are not made available for development until there is an identified need for six (6) new beds. In the case of new facilities, I think this makes perfect sense. But in this case, given that there are *only five* inpatient beds in Cleveland County today, and these only after an initial project and then an extension several years later, makes me believe that if four (4) beds will be needed in 2008, then it might make sense to consider making them available for development in 2008.

Here are some points I would argue for that consideration:

- The SMFP Draft notes a 2008 deficit of 4 inpatient beds.
- The census for Wendover for several years has been at or near 100%.

138 Conifer Way | Shelby, NC 28150 | Phone/Fax: 704-482-5751 | mhudson2@earthlink.net

- An average census at this level means that some patients had to be denied treatment, a horrible situation for such an emotional service,
- Hospice and Palliative Care Cleveland County has been the only hospice provider in Cleveland County since 1985 and is exceptionally well recognized by the lay and clinical communities,
- The organization continues to grow and sees a very large percentage of patients who die in the county,
- The organization is well run, maintains high quality, is JCAHO accredited and has excellent finances for a not-for-profit organization
- In terms of rational health planning, it has proven that it can plan ahead for service needs and address them cost effectively, and finally,
- The organization has never turned away a patient for financial reasons; if beds have been available, patients and their loved ones have been welcomed.

I recognize that even if the committee agrees with the petition, there will still need to be a Certificate of Need application submitted. That, in turn means that the beds could not likely be put in service until late 2008 at the earliest. I wonder, given the high census that Wendover is seeing now, what might the bed need be a year from now?

And how many patients and their families in Cleveland County that need this wonderful service won't be able to get it?

Sometimes we forget that all the buildings, machines and services we deliberate about serve a common purpose....to care for human beings in their time of need.

Thank you for allowing me the opportunity to comment and voice my opinions.

Sincerely,

Mark Alan Hudson, FACHE
President

Comments of Jay Rhodes

Regarding Special Needs Petition of Hospice & Palliative Care Cleveland County

SHCC Public Hearing on July 25, 2007

Thank you for allowing me a few moments to speak to you today regarding the request of Hospice & Palliative Care Cleveland County for a "special needs" petition regarding additional inpatient beds for the 2008 State Medical Facilities Plan. I hope you will forgive me if I incorrectly use or don't fully understand all of the terms you have to use in this process. I am a lay person and a volunteer so this is not my "home court."

I think that others who will speak to you today and many who have written letters of support for us may be more eloquent in their language. I would simply like to speak to you as someone who believes in the concept of hospice and especially in the organization whose board I am honored to chair. I came to the board of Hospice & Palliative Care Cleveland County in 1995 for a very personal reason; my father had been a patient there. I served for a number of years and then rotated off and then was asked to serve again. I have had the opportunity to serve on the Strategic Planning Committee, and was chair of the Finance Committee and have served as Board Chairman twice during my years of service.

I share this not to brag, though I am proud of being able to serve, but to convey to you that I know a lot about this organization, its mission, its caring and its success. Since I joined the board, the organization has grown tremendously and has been able to maintain its standards of quality and compassion while meeting its financial obligations. I can tell you this organization is highly respected by both the clinical community and the community at large; it receives substantial contributions each year from individuals and families touched by its mission.

As a Board, we are connected to the mission of the organization; each month at our meetings, a staff member shares a story about a patient and family who has been touched by our hospice. Often, these stories move many of us to tears, both for the sadness of loss but also because of the remarkable dedication of our staff and of the human spirit we often witness. We KNOW that we are doing good work.

It is therefore frustrating to those of us who do not work within the healthcare system to understand all the rules and regulations that must be adhered to. It sometimes seems like Pandora's Box to us; whenever we want to do something that makes sense to us and will help our community, there are unexpected and difficult challenges that appear. These sometimes, on the face, seem unfair or misguided to those of us not familiar with your world.

But I have also seen this system work and believe in playing by the rules. And I strongly believe that when a rule doesn't make sense given the facts at hand, it should be appropriately and respectfully challenged. And that is what we are doing today.

As a lay person, this is what I know:

- We are the only hospice organization in Cleveland County.
- Our inpatient occupancy is at 100% and has been for some time now.
- The 2008 SMFP says our county will be short four inpatient beds in 2008 based upon utilization of our beds in the past.
- We have had to turn away patients and families in substantial numbers because beds are not available.
- If the beds were available for development in 2008, and if awarded them through a CON, we would be in a position to financially and economically add them AND MOST IMPORTANTLY, care for the people who need our services.

Given these "facts," it seems to be a reasonable request to ask that you carefully consider our request to make the four inpatient beds, which the State clearly thinks are needed, available for development in 2008.

In closing, I earlier made a reference to the mythological "Pandora's Box." I think it is interesting that the last thing to come out of that box was "hope." Our hope is that our information is compelling enough so that a "special need" is recognized for this very special type of care in our county.

Thank you very much for allowing me this time and for your attention.

Comments of Becky Cook

Regarding Special Needs Petition of Hospice & Palliative Care Cleveland County

SHCC Public Hearing on July 25, 2007

My name is Becky Cook. I am a hospice patient/family volunteer; but my experience with Hospice & Palliative Care Cleveland County has also included three family members as patients. My mother-in-law, Mildred, was at Wendover for her last 48 hours. My husband, Ken, died at home with hospice care. Most recently, my daughter, Terrie, was a patient.

Terrie was born with problems and developed many others over time. Ken and I kept her at home until she was 38 years old. After Ken died, it became impossible for me to care for her at home so I had to place Terrie in a group home. For four years, this worked out well.

Eventually, her physical condition got so bad that we were asked to make plans to leave. After many prayers and many sleepless nights, a friend asked if I had read about Hospice adding new beds at their facility, Wendover.

I didn't want to believe that Terrie was actually hospice appropriate; however, I called the executive director, asked a few questions, and got the information I needed. At that time, Wendover had no beds available so Terrie was put on the waiting list.

A homecare team from hospice began seeing her at the group home. Through their care, experience, and observations, the team realized that Terrie's problems were much worse than the workers at the group home were telling me and helped me begin to face the reality that Terrie's health really was declining. Even though I was in denial about how bad Terrie was, if she was terminally ill, I knew her care at Wendover would be so much better than what she would receive in a nursing home. The patient/staff ratio – alone – would be so much better. My only hope was for a bed to become available soon.

On April 12th, 2004, Terrie was moved to Wendover. She was blind. She was unable to communicate in any way. She had no use of her arms, her hands, or her legs. She had no control over any bodily functions. Terrie was a new experience for most of the Wendover staff so I became their educator.

The entire staff – everyone involved – worked so hard to give her everything she needed to be comfortable. I was finally at peace knowing that she had hospice care 24 hours a day.

When the Wendover nurse told me that Terrie's days were numbered, I moved into Wendover with her. On June 15th, just two months and three days after Terrie moved into Wendover, she took her last breath, surrounded by loving, caring people.

Death isn't something any of us look forward to; however, it is a certainty for all of us. There is such a need for places like Wendover. Places where people can die with peace and dignity. Places where family members can be assured that their dying loved ones are getting excellent love and care.

Wendover always has a waiting list. I remember what it was like having Terrie's name on that waiting list. I pray for the patients and their family members who are waiting now . . .

Thank you.

Comments of Myra McGinnis

Regarding Special Needs Petition of Hospice & Palliative Care Cleveland County

SHCC Public Hearing on July 25, 2007

Good afternoon. I am Myra McGinnis, Executive Director of Hospice & Palliative Care Cleveland County. I am here today on behalf of our petition for a special need adjustment of four additional hospice inpatient beds in Cleveland County, which appear in the Proposed 2008 State Medical Facilities Plan as a deficit of four beds in Cleveland County. Since 1996, Hospice & Palliative Care Cleveland County has operated Wendover—*The Kathleen Dover Hamrick Hospice House*, a combination facility currently with five inpatient beds and nine residential beds. The facility has been very successful, as evidenced by our occupancy rate for inpatient beds, which was 100 percent in 2005 and 99.9 percent in 2006. So far in 2007, our occupancy has averaged 100 percent.

Unfortunately, the success with which our facility has been incorporated into the community's health care system and the limited number of inpatient beds have combined to create demand that we cannot meet. Last year, we were forced to turn away 58 patients who needed to be admitted to our facility, but who were denied admission because no bed was available. On any given day, we have a waiting list averaging six or more patients who need admission to the inpatient facility, but

without more beds, we cannot provide services to these patients in the most appropriate setting. The result is that patients and families do not get the optimal care they need and often encounter unnecessary stress at the worst possible time.

The current standard hospice inpatient bed need methodology requires a minimum need of six beds before allocating beds to a single county. ***There is no provision, however, for an existing facility operating at near 100 percent occupancy to gain additional capacity.*** Presumably, under the current standard methodology, we would be required to wait until the deficit reaches six beds before we could expand our facility. Given the number of patients we are already turning away, we believe that alternative is not acceptable.

We are asking that you simply acknowledge what the standard need methodology indicates—that there is a need for four additional hospice inpatient beds in Cleveland County—and allocate these four beds to the State Medical Facilities Plan now. We believe this request is supported by circumstances that do not exist elsewhere in the state, which include:

1. A hospice inpatient facility already exists in Cleveland County;
2. The existing facility is consistently operating at 100 percent occupancy;

3. Local hospitals and physicians recognize and support our facility as the standard for end-of-life care in our community;
4. The lack of available beds has led to a waiting list and to patients being denied access to our specialized care.

We believe these factors give rise to the need for a special adjustment of the four additional hospice inpatient beds—which the current methodology shows are needed now in Cleveland County. This special adjustment will allow us to continue providing high quality hospice inpatient care to all in need.

Thank you for your consideration of our request.

Petition Inpatient Hospice – 2
Received Regarding Proposed 2008 State Medical Facilities Plan

Attached are:

1. Petition from Hospice and Palliative Care (Forsyth County)

2. Comments received at various Public Hearings. (Note: the comment submitted at the Greensboro hearing is not included as it appears to be a duplicate of the comment received at the Asheville hearing.

3. Additional material received including letters from the petitioner, support letters provided by the petitioner and a letter opposing the petition.

Hospice & Palliative
CARECENTER

August 3, 2007

Mr. Floyd Cogley, Planner
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Re: Hospice & Palliative Care Center Petition to adjust the 2008 State Medical Facilities Plan Need Determination for Hospice Beds in Forsyth County

Dear Mr. Cogley:

Hospice & Palliative Care Center (HPCC) respectfully submits the attached petition for a need adjustment for ten (10) additional hospice inpatient beds and ten (10) additional hospice residential beds in Forsyth County.

As the attached petition will discuss in detail, HPCC supports the existing methodology for hospice beds. However, HPCC serves patients from a metropolitan service area that includes patients from many counties and the existing methodology's county based service area does not address the need for hospice services at our facility. The proposed beds in the petition can be added without capital cost to the health care system and will assist us in meeting the unmet demand that we are already experiencing.

This petition is the result of years of thoughtful planning involving leaders in our area and comes with the full support of area health care leaders.

Please do not hesitate to contact me for additional information. I look forward to the opportunity to support this petition further during the review process.

Sincerely,

JoAnn Davis
President and CEO

Hospice & Palliative Care Center Petition to the State Health Coordinating Council to adjust the 2008 State Medical Facilities Plan Need Determination for Hospice Beds for Forsyth County

Executive Summary

Petition: Adjustment for ten (10) additional hospice inpatient beds and ten (10) additional hospice residential beds in Forsyth County

Current bed complement:	**Needed bed complement:**
20 Hospice IP Beds	30 Hospice IP Beds
10 Hospice Residential Beds	20 Hospice Residential Beds

Need Methodology:

Scenario 1: Patient Origin*SMFP need by county 25 Hospice IP Beds
Scenario 2: Number Patients Denied Access*ALOS 31 Hospice IP Beds
Residential: 1.5:1 ratio of Hospice IP:Residential 20 Hospice Residential Beds

Rationale:

Access
- In 2006, at least 269 patients who were candidates for the Kate B. Reynolds Hospice Home died while waiting for a bed
- In 2006, on 367 days, more than one person occupied a Hospice IP room
- Hospice IP occupancy rate is currently 104-110% and residential is 93%
- Both hospitals in Forsyth County are operating near capacity and there is a 198 bed deficit of nursing home beds in Forsyth County

Cost
- The proposed beds will save $14 million annually in medical costs
- No cost to the health care system:
  - The ten inpatient beds can be added at zero cost
  - The residential beds will be funded by a capital campaign

Quality
- HPCC is staffed with a multidisciplinary team of full-time medical directors, residents, nursing and paramedical professionals
- HPCC offers a full continuum of end-of-life services to patients and their families that is greatly valued by the specialists in Winston-Salem that continue to refer patients to HPCC
- Hospice patients can have a longer lifespan than patients treated in a hospital setting

Adverse effects to service area if not approved:

- At least $14 million in medical costs will be incurred annually as patients are admitted to hospitals rather than hospice inpatient beds
- 268 Medicare, 21 Medicaid, 14 Indigent/Self-Pay and 41 Commercial (344 total) patients annually will not have access to hospice services each year

Not Duplicative:

- HPCC asks for these beds in order to maintain the level of service *presently demanded* by residents and physicians of Forsyth and contiguous counties.
- HPCC will continue to complement rather than compete with the services available in the counties contiguous to Forsyth

Petition and Rationale

Petition

Hospice & Palliative Care Center (HPCC) hereby petitions the State Health Coordinating Council (SHCC) to adjust the 2008 State Medical Facilities Plan to allow for a regional adjustment for ten (10) additional hospice inpatient beds and ten (10) additional hospice residential beds in Forsyth County.

Identification of Petitioner

HPCC is a comprehensive center that provides support, guidance, palliative and hospice care to patients and their loved ones on every step of the path from serious illness to end-of-life care. HPCC, founded in 1979, was the first hospice in North Carolina. Since our beginning, our philosophy has been that when Hospice care is appropriate and desired by the patient and family, it is the most cost-efficient setting for end-of-life care. HPCC has grown to four offices located in Winston-Salem, Mocksville, Walnut Cove, and Salisbury to serve patients and their families from 13 counties. The hospice inpatient and hospice residential beds at the Kate B. Reynolds (KBR) Hospice Home in Forsyth County will be the focus of this petition.

One of the most unique aspects of HPCC in Forsyth County is that it operates as a freestanding entity with the full support of the hospitals and nursing homes in Forsyth County. Both of the hospitals in Forsyth County are major regional referral centers offering tertiary and quaternary services. HPCC acts in a similar manner, offering a full spectrum of end-of-life services and providing advanced levels of clinical staffing. The patients that are referred to HPCC are referred by their physicians because HPCC offers the full spectrum of services and the level of service makes HPCC the most suitable provider for the patients. Further, we have long established referral relationships with both the Baptist and Novant systems and both recognize that HPCC is the most appropriate provider for patients who have been treated in either system.

The senior management leaders from both general acute care hospitals sit on the board and both hospitals provide support for the HPCC and have been long time advocates for our services. Please reference Exhibit 1 for evidence of that support in the form of letters of support from leaders of each hospital in Forsyth County.

HPCC is currently licensed for twenty (20) hospice inpatient beds at its Kate B. Reynolds Hospice Home and ten (10) hospice residential beds. All thirty (30) beds are built to the hospice inpatient standards and are located in facilities that are physically connected. In addition to onsite hospice care, hospice home care and palliative home health services are provided. HPCC also staffs specialized teams dedicated to serving the unique needs of pediatric and long-term care populations. The community is offered education and counseling in the grief center and through a lending library. Palliative care consults are also provided. HPCC considers the needs of the entire family in addition to the patient needs. All services are available to the whole family.

HPCC has four full-time medical directors, one fellow and two nurse practitioners. In addition, there are 64 registered nurses, 23 licensed practical nurses and 53 nurse assistants on staff. It is important to note, HPCC has a depth of clinical resources skilled in end-of-life clinical care. In most cases, the only element that prevents us from providing hospice care to more than twenty

inpatients and ten residential hospice patients at our facility at any given time is the actual license for beds.

HPCC is dedicated to the education of clinicians. All 3rd year medical residents at Wake Forest University School of Medicine spend 68 hours rotating through HPCC. Medical fellows also spend time in Hospice. Nursing, social work and other clinical staff are also trained at HPCC.

HPCC is proud of the trust the community places in its ability to provide services at the end-of-life. The community support is evident by the fact that so many patients and their families work with their physician to seek hospice at HPCC. In addition, the community's financial support is an example of how much the community values the HPCC. In 2006, the community provided $1.8 million in support. During the 2006 United Way campaign, 1,750 individuals in Forsyth County alone designated HPCC as their agency of choice.

It is the physicians who ultimately ensure the success of the HPCC as all hospice requires a physician referral. In 2006, the Kate B. Reynolds Hospice Home in Forsyth County received 722 referrals (including 316 that could not be accepted due to capacity constraints).

Reasons for the Proposed Adjustment

The state has developed methodology to project the need for hospice inpatient beds across the state, and we support this methodology. However, the situation in Forsyth County poses a unique challenge because the demand for hospice has pushed the existing facility beyond capacity. The central reason that the state methodology does not recognize the need soon enough for Forsyth County is the fact that HPCC in Forsyth County serves patients from a metropolitan service area that includes patients from many of the outlying counties. The SHCC methodology recognizes each of the 100 counties as a separate service area. In practice, HPCC in Forsyth County serves a 13 county service area and 29% of our hospice inpatient and 22% of our hospice residential patients' homes are outside of Forsyth County. (2007 License Renewal Application)

As the volume of demand for hospice at HPCC continues to grow, we find ourselves increasingly operating above capacity. When all of the current hospice inpatient and hospice residential beds are full, HPCC finds itself in the unpleasant position of reducing or restricting access. As a result, we are concerned that without the additional requested beds, we will not be able to continue to offer potential patients the most cost-efficient setting for end-of-life care.

The HPCC in Forsyth County has developed two alternative scenarios to support the additional need for hospice inpatient beds. They are provided in Exhibit 2 and are summarized as follows:

- Scenario 1: Adjusts the 2012 SMFP need for each of the counties where HPCC has historically drawn patients by applying the percentage of patient origin for those counties to the SMFP need determination. It is important to note that HPCC does not suggest that those counties should have their need determinations reduced; rather we ask that in this special need determination, the reality that we draw patients from more than Forsyth County be acknowledged to allow us to develop additional beds. This adjustment results in the need for 25 hospice inpatient beds.

- Scenario 2: Converts the historical number of patients on the waiting list that were never admitted to HPCC in Forsyth County to days of care using the historical average length of stay. This demand can then be added to the projected patient days of 5,433 for 2012 in the SMFP and then divided by the 85% occupancy rate. When this methodology was averaged over the past two years, the adjustment results in the need for 31 hospice inpatient beds

Based on the results of both of these scenarios, HPCC is requesting 10 more inpatient hospice beds for a total of 30 hospice inpatient beds.

While Hospice residential does not have an official SMFP need methodology, we have historically offered a 2:1 ratio of hospice inpatient:hospice residential beds. With our planning for the proposed petition, we project that a ratio of 1.5:1 hospice inpatient:hospice residential beds will allow us to serve our future patients in a cost effective manner. The 1.5:1 ratio is consistent with the statewide ratio of hospice inpatient beds:hospice residential beds of 1.54 (273 approved and pending hospice inpatient:177 approved and pending hospice residential on pages 286 and 287 respectively of the 2008 Draft SMFP). Following the 1.5:1 ratio results in the need for 20 hospice residential beds.

It is important to note that Medicare's respite benefit requires that care be provided in a licensed bed. The hospice residential beds are the most cost-effective location for respite patients, however when we run at near 100% capacity, respite patient opportunities are often limited. The proposed additional residential beds will assist HPCC to continue to offer residential as well as respite services to the community.

Access to Hospice Services for New Patients is Impaired when Operating at 100% Occupancy

In addition to the information provided in Exhibit 2 and described above, the following data provides evidence of the need for additional hospice inpatient and hospice residential beds:

- In 2006, at least 269 patients died while waiting for a bed at the Kate B. Reynolds Hospice Home.
- The occupancy rate of hospice inpatient beds was 106% in the first four months of 2007 and 104% in 2006. In two of the last five months, the occupancy rate has been 110%. Reference Exhibit 3 for occupancy by month.
- The occupancy rate of hospice residential beds was 93% in the first four months of 2007 and 78% in 2006. In one of the past five months, the occupancy rate was 100%. Reference Exhibit 3 for occupancy by month
- The occupancy rates greater than 100% underscore a critical strain on the capacity of hospice beds. The days in excess of 100% are only possible because multiple patients were in the same room on the same day. This is a quality indicator of a missed opportunity to offer a patient and their family more time in hospice. There were 367 days in 2006 and 156 days year to date in 2007 (through May) when more than one patient used the same bed on the same day.
- The average length of stay for hospice inpatients has been 12 in the past two years. The same figures for hospice residential were 53.43 days in 2006 and 38.9 days from Jan-May 2007. In Hospice, a declining length of stay may not be a positive result, but rather may indicate constraints on access. Some studies of physicians beliefs about hospice have shown

that physicians believe patients should ideally receive hospice care for 3 months before death.(1)

- The vast majority of HPCC patients are from medically underserved populations. Medicare patients make up 78% and Medicaid 6% of the payer mix. Indigent and self-pay consists of an additional 4% of patients. The Medicaid and indigent percentages are understated as Medicare does not allow HPCC to bill for secondary payers such as Medicaid. The 78% Medicare therefore includes dual eligibles (patients with both Medicare and Medicaid) and some financially indigent patients. It is important to note that no patient is ever denied service based on their prognosis, diagnosis or ability to pay for HPCC services.
- The State methodology does not consider the growing undocumented immigrant population. Forsyth County has one of the fastest growing populations of undocumented immigrant residents in the State of North Carolina. As these residents remain as long-term residents, they may need Hospice services. In 2006, HPCC in Forsyth County had 49 patients that were undocumented immigrant residents, mostly young children.
- The pediatric daily census has been climbing significantly since September of 2006 and has nearly doubled year to date 2007. When the hospice inpatient and hospice residential beds are full, we are concerned that we may not be able to continue to serve this important population and their families.
- As other providers in Forsyth County face capacity constraints, the demand for hospice is directly impacted. According to the 2007 State Medical Facilities Plan, North Carolina Baptist Hospital is operating at 73% capacity and Forsyth Medical Center is operating at 87% capacity.[1] Both of these rates are based on historical information and do not consider additional capacity limiting factors such as specialty units, infectious control and gender. Further, there is a 198 bed deficit of nursing home beds in Forsyth County.
- The population over 65 in Forsyth County is expected to grow 12% in the next five years.[2]
- HPCC recognizes that other hospice beds have recently been approved in Surry (13) and Davidson (9) that will partially address the future demand for hospice services in those counties. However, HPCC does not expect these additional beds to impact its historical service share of 12.4% Surry and 17.4% Davidson in those counties. As discussed above, HPCC is unique with its full spectrum of services and will continue to experience demand from these counties for patients as they transfer from the two referral medical centers.

When the hospice inpatient beds operate in excess of 100%, the HPCC is faced with a number of simultaneous challenges that impair its ability to grant access to all of the patients that seek hospice services. First, when the hospice inpatient beds are full, new referrals cannot be accepted from area hospitals. Second, existing patients in hospice residential beds whose condition worsens cannot be converted to hospice inpatient care due to the licensing requirement. This is true even though the hospice residential patient may be in a bed that is built to a hospice inpatient standard. HPCC typically offers the higher level of medical care to the patient but is not able to seek additional reimbursement because the bed is not licensed as a hospice inpatient.

The demand for end-of-life services is a natural process. At any given time, a proportion of the population is facing the need for end-of-life services. At the point at which a patient is a

[1] Table 5A from SMFP: NCBH 197,023 Days 365 Days 738 Beds 73.1%; FMC 202,374 Days 365 Days 637 Beds 87.0%

[2] Population Projection by Age Group Tables, North Carolina State Demographer, www.demog.state.nc.us, accessed June 19, 2007, 2012 estimate of 47,292, 2007 estimate of 42,244

candidate for end-of-life services, they are going to seek treatment wherever it is available. When Hospice is not available, patients will seek treatment in a hospital or nursing home. At HPCC, we operate under the premise that when Hospice care is appropriate for a patient, hospice is the most cost-efficient setting for that care

During periods where the hospice inpatient beds are full and hospice residential patients who require hospice inpatient care cannot be transferred, a subsequent access challenge is created for incoming hospice home care patients. Patients that are already in our hospice home care service who are in crisis (their condition reaches a point where they cannot safely be cared for in the home setting) can be denied admission to hospice inpatient when the beds are full.

Because of the high rate of hospice utilization, HPCC has been forced to contract with the palliative care units of area hospitals to house hospice patients that cannot be transferred to HPCC of Forsyth because of capacity challenges. In these cases, the patient is discharged from the hospital and admitted to HPCC but remains in the palliative care unit of the hospital. While these palliative care units are staffed with appropriate clinical resources, the patient and families are not afforded access to the positive physical environment and resources that are located on the HPCC campus. Further, as both hospitals continue to be challenged with inpatient bed capacity of their own, their ability to offer this arrangement is increasingly impaired.

Offering the Highest Quality of End-of-life Care to all the Potential Patients is Not Possible without additional Beds

There is growing emphasis for end-of-life care by the public health community as well as payers. The gap between the potential for hospice care among patients approaching end-of-life and actual referrals to hospice continues to be studied. One large study of Medicare beneficiaries found that of 260,000 Medicare beneficiaries with cancer as first diagnosis, only 21.1% of patients received hospice care before death.(2) According to 2005 data reported by the Carolinas Center for Hospice and End of Life Care, 36.97% of Forsyth deaths are served by hospice. We are proud of the fact that the rate in Forsyth is 10th highest in the state and highest by far among the other metropolitan counties such as, Mecklenburg (33rd), Wake (14th), Guilford (48th), Durham (31st) Buncombe (24th) and New Hanover (12th). The North Carolina average is 28.14%. However, we recognize that the opportunity to serve even more patients who are candidates for hospice continues. As more patients are served by Medicare Advantage plans, and Medicare continues its emphasis on hospice as an end-of-life treatment option, we anticipate increased demand for hospice services.

In addition to the improved atmosphere and quality of life for patients during the end-of-life phase, a recent retrospective analysis just published in the Journal of Pain and Symptom Management found that mean survival was 29 days longer for hospice patients than for nonhospice patients.(3) The study reviewed records from 4493 Medicare beneficiaries who had one of five types of cancer or congestive heart failure. The study authors hypothesize that the reasons for longer survival could be 1) patients are forgoing aggressive cure directed therapy and associated mortality, 2) Medicare's hospice benefit allows additional medications and 3) the psychosocial supports in the hospice setting may prolong life.

We believe quality health care is the direct result of staff competencies and training and are committed to the continuing education and certification of our employees. All of the physicians on the HPCC team are Board certified in Hospice & Palliative Medicine and many of our nurses and

nurse assistants are certified with national certification in hospice and palliative care. In addition, all of our grief counselors are Masters-level prepared and have national certifications. Five of our employees are accredited with community disaster response

The HPCC staffs both its hospice inpatient and hospice residential beds with a 24 hour multidisciplinary team. A physician is available on-call to respond to the needs of patients and engage in joint planning with the primary care physician. Since these staff are already in place, we can offer hospice inpatient services to all 30 beds if we were licensed for 30 hospice inpatient beds Only a moderate amount of incremental operational clinical staff would be required to increase from 10 to 20 hospice residential beds. Without the additional beds, our services are capped at 30 total beds and other potential patients will have to be denied access in the future, not because we don't have the clinical competency and staffing in place but solely because of a licensing restriction.

The HPCC is accredited by the Accreditation Commission of Health Care. The HPCC is the recipient of numerous national awards including the Circle of Life Award, presented by the American Hospital Association, the American Association of Homes and Services for the Aging, and the American Medical Association, the "End-of-life Care Leadership Award" presented by the Carolinas Center of Hospice and End-of-life Care, and the Joel A. Weston, Jr. Memorial Award recognizing excellence in nonprofit management.

The Cost Efficiency of End-of-life Care to the Community is Suboptimal in Absence of Additional Beds

Studies of hospice care in the clinical literature are increasingly recognizing hospice is a more cost-effective setting than an inpatient hospital for end-of-life care. In a recent retrospective review of patients who expired with ovarian cancer, the cost of care was much lower in the hospice group at $15,164 per patient as compared to $59,319 per patient in the non hospice group.(4) A study comparing deaths of Medicare beneficiaries in Massachusetts and California to determine how hospice affects the expenditures for the last year of life, found that among patients with cancer, expenditures were 13% to 20% lower for those in hospice. (5) Another study reviewing the opportunities for cost savings in an optimum model of coordinated, expert, high-volume care (including hospice, palliative care and early use of advance directives) end-of-life hospitalization can be prevented with cost savings as much as 70%.(6)

At HPCC the daily charges to Medicare and private payers is $600 per day for hospice inpatient and $140 for hospice residential patients. These costs can be several thousand dollars lower than the costs patients might incur if they remained in inpatient acute care or a nursing home. The last few days of care for patients that die in an inpatient hospital or a nursing home are widely acknowledged to be the most costly days of the patients' admission.

If all of the patients on our waiting list continue to seek care in the hospitals in Forsyth County, the potential cost to the health care system is $14 million. This estimation was calculated by converting the average of the last two year's waiting list, 344 patients, to potential patient days of 4,128. We then calculated the difference in cost of care $4,000 (average cost per patient day based on recent CON applications in Forsyth County) less the $600 hospice reimbursement $3,400. This amount was multiplied by the 4,128 patient days resulting in an annual excess cost of $14,035,200. See Exhibit 4 for the detailed calculation.

Though HPCC has been able to establish contracts with local hospitals to place patients in the palliative care units when all of the twenty (20) licensed beds are full, these relationships are not as cost-efficient as care on the main campus. Even with agreeable terms with the local hospitals, the contract requires that clinical staff travel between sites to manage the patient's care which unnecessarily increases staffing costs.

As previously discussed, all of the current ten (10) hospice residential beds are built to the hospice standards so they can be converted to hospice inpatient without any additional capital expenditure. If this petition is approved and HPCC submits a successful CON application, next year, a new twenty (20) bed hospice residential facility would be built on the current campus in Winston-Salem. The costs of the new center would be funded by a capital campaign.

Adverse Effects on the Population If the Adjustment is Not Made

Without the requested additional hospice inpatient and hospice residential beds, patients who are at the end-of-life who have made the hard choice of moving into hospice may continue to be placed on a waiting list, or worse, denied access to KBR.

Patients who are without any other support system to experience death with dignity in the home will not be afforded the opportunity at KBR. Patients who are economically disadvantaged that cannot afford alternative settings to KBR may be forced to seek care in a hospital or nursing home and incur costs that far outweigh the patient's resources. A projected 268 Medicare, 21 Medicaid, 14 Indigent/Self-Pay and 41 Commercial patients annually will not have access to hospice services each year.

KBR will be forced to continue to operate at levels over capacity, which will undermine our ability to provide the level of attention to each patient and family member deserves as we spend more of our time managing the patient turnover to free up additional beds.

The costs to the community for the patients that remain on the waiting list will continue to be $14 million or higher as patients will continue to be denied immediate access to the lower cost hospice setting. In addition, the operating costs will continue to escalate and cost inefficiencies will continue for HPCC as we attempt to manage patients in multiple settings (including the hospital based units) and we have to staff overtime to meet the demands of operating a unit at more than 100% capacity. Further, without the additional hospice residential beds, fewer patients will be offered the alternative of the lower cost hospice residential setting.

Finally, patients will not be afforded access to the recognized quality services of HPCC. HPCC staff will be increasingly challenged to perform the continuous quality improvement efforts when they are facing capacity overload in the patient care arena.

No Feasible Alternatives

HPCC considered several alternatives including: 1) status quo, 2) referring patients to hospice programs in the service area and 3) this petition.

The Status Quo is not acceptable to HPCC because access will continue to be denied to patients and their providers who are reaching out for our services at the time of greatest need for the

patient. The Status Quo means as many as 316 patients may be left on the waiting list again this year and perhaps more in the future. Even our temporary efforts to place patients on Palliative Care units at Forsyth Medical Center (FMC) or North Carolina Baptist Hospital (NCBH) are less than ideal for the patient, as those units while as pleasant as they can be are no match for our comfortable setting at KBR. Patients who are placed in the hospitals under a contract with HPCC are often too close to the opportunity for additional procedures that they would likely not consider if they had been placed directly in a hospice setting. Further, the status quo means staff and patients who do have access will continue to experience a center that is operating over capacity.

Referring patients to other hospice programs in the region may seem like a reasonable alternative when reviewing the SMFP. However, referring patients to counties other than Forsyth, even when the patient is not from Forsyth is not practical. Most of the patients that we receive from other counties have been referred to HPCC because they have already come to Winston-Salem for treatment at one of the referral medical centers. As noted earlier, once patients have received care in the Baptist or Forsyth/Novant networks, they are very inclined to continue their final care with HPCC as we have established referral relationships and a reputation for a full spectrum of end-of-life services with both health systems. When the patient makes the choice for Hospice, they often want to remain in care that is delivered in collaboration with their specialist who is usually based in Winston-Salem. Further, the hospice programs in neighboring counties are dedicated to serving the needs of their own local populations and referral sources.

This petition is the only alternative that will allow HPCC to meet the current and future demand for high quality Hospice & Palliative Care services in a cost-effective manner.

The Requested Adjustment Will Not Unnecessarily Duplicate Health Services

HPCC is the only regional hospice program in the area and the oldest hospice program in North Carolina. Other local hospice programs in our service area can continue to meet the needs of their populations and most will remain well utilized even if we are granted the opportunity for additional hospice inpatient and hospice residential beds.

The proportion of patients we expect to serve in 2011 by Hospice & Palliative Care Center in contiguous counties to Forsyth where there are other providers is fairly modest (see Exhibit 2 for calculation): Davidson (21.6% - 49 patients), Guilford (0.8% - 6 patients), Rockingham (1.6% - 2 patients), Stokes (35.5% - 38 patients), Surry (1.9% - 9 patients) and Yadkin (32.5% - 17 patients). Note that Davie (79.3% - 54) is higher but there are no other hospice providers serving a significant proportion of Davie County. These modest figures underscore the fact that HPCC is proposing to serve its existing referral base with the proposed beds.

HPCC is the only hospice program in the State and one of the few in the United States that enjoys the complete support of both area regional referral centers. We are also the only hospice program in Western North Carolina affiliated with a children's hospital.

We are confident that we can continue to work with other providers in the service area to complement rather than duplicate services. Our review of the SMFP and the demographic shifts that the area is facing, and the growing awareness by the provider, payer and patient communities and focus on hospice as a desired end-of-life option will continue to provide a growing patient population to serve in the future.

Conclusion

For all the foregoing reasons, we strongly encourage the SHCC to consider carefully the petition presented by HPCC and determine there is a need for ten (10) additional hospice inpatient beds and ten (10) additional hospice residential beds in Forsyth County.

Respectfully submitted this 3rd day of August 2007.

Hospice & Palliative Care Center

By: _____
JoAnn Davis
President

101 Hospice Lane
Winston-Salem, NC 27103
Telephone: (336) 768-3972

Exhibits:

1. Letters of Support
2. Adjusted Need Scenario Projections
3. Historical Occupancy Rate 2006 & Year to Date 2007
4. Adverse Impact Calculation

Reference List

(1) Lamont EB, Christakis NA. Physician factors in the timing of cancer patient referral to hospice palliative care. Cancer. 2002;94:2733-37.

(2) McCarthy EP, Burns RB, Ngo-Metzger Q, Davis RB, Phillips RS. Hospice use among Medicare managed care and fee-for-service patients dying with cancer. JAMA. 2003;289:2238-45.

(3) Connor SR, Pyenson B, Fitch K, Spence C, Iwasaki K. Comparing hospice and nonhospice patient survival among patients who die within a three-year window. J Pain Symptom Manage. 2007;33:238-46.

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(5) Emanuel EJ, Ash A, Yu W, Gazelle G, Levinsky NG, Saynina O et al. Managed care, hospice use, site of death, and medical expenditures in the last year of life. Arch Intern Med. 2002;162:1722-28.

(6) Payne SK, Coyne P, Smith TJ. The health economics of palliative care. Oncology (Williston Park). 2002;16:801-8.

Forsyth MEDICAL CENTER

July 30, 2007

Mr. Floyd Cogley, Planner
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Center
Raleigh, NC 27699

Re: Hospice & Palliative CareCenter Petition to the 2008 State Medical Facilities Plan for an additional tem (10) hospice inpatient and ten (10) hospice residential beds.

Dear Mr. Cogley:

The purpose of this letter is to provide support for the proposed Hospice & Palliative CareCenter (HPCC) Petition to the 2008 State Medical Facilities Plan (SMFP) for an additional ten (10) hospice inpatient and ten (10) hospice residential beds. Forsyth Medical Center (FMC) works very closely with HPCC to place appropriate patients that are in need of hospice services. Our leaders provide advisory leadership and our staff work directly with the staff of HPCC to continuously improve the transition of care settings for patients and their families.

As you may be aware, HPCC is currently operating at 106% on its hospice inpatient beds and 93% on its residential beds so far this year. This is well above the SMFP occupancy assumption of 85%. When the occupancy rates are pushed this high on a consistent basis, the need for additional capacity is apparent. The current capacity challenges at Kate B. Reynolds (KBR) Hospice Home directly impact FMC and our efforts to ensure all appropriate patients have access to KBR. Patients at FMC that desire a transfer to the KBR setting are sometimes delayed or even denied admission because there are not enough licensed beds. This is especially frustrating to our clinical teams when they realize that the strong quality clinical resources are in place at KBR but they are not available simply because of a licensing issue.

FMC is a regional provider of comprehensive clinical services and we often see patients that are referred to this area due to the complexity of their condition. In the event that these patients are appropriate candidates for hospice, they often want to be referred to HPCC because of the services provided and the skill level of the staff. I am hopeful that you will provide a positive review of the HPCC petition and grant the requested adjusted need determination for the 2008 SMFP so that more patients who wish to seek HPCC services will be provided access.

Please accept this letter as an indication that FMC is in full support for the petition for HPCC for additional hospice inpatient and residential beds. Thank you in advance for your consideration. Please do not hesitate to contact me for further information or support of this important endeavor.

Sincerely,

Sallye Liner

Sallye Liner,
COO, Forsyth Medical Center

Wake Forest University Baptist
MEDICAL CENTER

July 30, 2007

Mr. Floyd Cogley, Planner
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Center
Raleigh, NC 27699

Re: Hospice & Palliative CareCenter Petition to the 2008 State Medical Facilities Plan for an additional ten (10) hospice inpatient and ten (10) hospice residential beds

Dear Mr. Cogley:

The purpose of this letter is to provide support for the proposed Hospice & Palliative CareCenter (HPCC) Petition to the 2008 State Medical Facilities Plan (SMFP) for an additional ten (10) hospice inpatient and ten (10) hospice residential beds. North Carolina Baptist Hospital (NCBH) works very closely with HPCC to place appropriate patients in need of hospice services. Our leaders provide advisory leadership and our staff work directly with the staff of HPCC to continuously improve the transition of care settings for patients and their families.

As you may be aware, HPCC is currently operating at 106% on its hospice inpatient beds and 93% on its residential beds. This is well above the SMFP occupancy assumption of 85%. When occupancy rates are pushed this high on a consistent basis, the need for additional capacity is apparent. At NCBH, we continue to face sustained demand for our own inpatient beds. When HPCC finds itself at or over capacity, the strain is felt in our area's entire health care system. Patients ready to leave NCBH for Kate B. Reynolds (KBR) Hospice Home must either remain in an acute care inpatient bed or be transferred elsewhere. In either case, the patients and families miss the opportunity to experience the KBR setting. This situation is very costly and not in the patient's best interest.

As a tertiary provider of services having a broad regional patient service area, I can appreciate the challenges that HPCC faces where the need determination does not fully recognize the demand for services in the Forsyth County location. I support and encourage you to review the HPCC petition and grant their request for 2008 SMFP.

Please accept this letter as an indication that NCBH is in full support of the petition by HPCC for additional hospice inpatient and residential beds. Thank you in advance for your consideration. Please do not hesitate to contact me for further information or support of this important endeavor.

Sincerely,

Donny C. Lambeth
Interim President
Chief Operating Officer

Exhibit 2

Hospice and Palliative Care Center of Forsyth
Projected Need for Hospice Beds Based on an Adjusted Approach to the SMFP Methodology

Scenario 1 Adjusted Need Based on SMFP Methodology adjusted for Historical HPCC Share

County	2005 Hospice Days of Care Per 1000	2011 Pop	2011 Estimated Days of Care	Estimated Inpatient	Projected Inpatient Beds	HPCC Share of SMFP	Projected Beds Share Adjusted	HPCC Days [illegible]	[illegible]
Forsyth	[illegible]	[illegible]	67,[illegible]	[illegible]	18	98.4%	19	[illegible]	[illegible]
Davidson	209.46	163,8[illegible]	[illegible]	[illegible]	7	21.6%		[illegible]	[illegible]
Davie	[illegible]	43,56[illegible]	[illegible]	8[illegible]	3	76.3%		[illegible]	[illegible]
Guilford	[illegible]	4[illegible],441	[illegible]	9,5[illegible]	[illegible]	[illegible]		[illegible]	[illegible]
Iredell	[illegible].12	159,34[illegible]	[illegible]	[illegible]	5	[illegible]	0	[illegible]	[illegible]
Rockingham	197.1	92,[illegible]	18,[illegible]	1,4[illegible]	5	[illegible]	0	[illegible]	[illegible]
Rowan	213.34	140,33[illegible]	[illegible]	2,4[illegible]	5	20.0%	1	48[illegible]	[illegible]
Stokes	328.08	49,044	16,[illegible]	1,287	4	35.5%	1	457	48
Surry	970.11	77,059	74,7[illegible]	5,980	19	1.9%	0	114	[illegible]
Wilkes	130.19	69,017	8,99[illegible]	719	2	4.2%	0	[illegible]	[illegible]
Yadkin	192.51	39,936	7,688	615	2	32.5%	1	20[illegible]	17
Total								7,477	665
			Projected Adjusted Need Under Scenario 1:				**25**		

Scenario 2 Adjusted Need Based on Patients that Could be Served if Waiting List & Historical Need Served

		2005	2006	Average
A	Annual Number Patients on Waiting List	372	316	344
B	Average Length of Stay	12	12	12
C	Potential Day of Care for Waiting List (Row A*Row B)	4,464	3,792	4,128
D	Add Projected Days Care 2011 from Table 13C SMFP	5,433	5,433	5,433
E	Total Projected Days (Row C+Row D)	9,897	9,225	9,561
F	Divide by 85% SMFP Occupancy Rate to determine Projected Days Capacity Needed	11,644	10,853	11,248
G	Divide by 365 to Determine Average Days Needed on Each Day (Unit Size)	32	30	31
	Projected Adjusted Need Under Scenario 2:			**31**

Exhibit 3

Hospice and Palliative Care Center of Forsyth
Historical Utilization for 2006 and 2007 YTD

2006	J	F	M	A	M	J	J	A	S	O	N	D	Tota
Inpatient Census	21	21	21	21	20	20	20	21	21	21	21	22	250
Inpatient Beds	20	20	20	20	20	20	20	20	20	20	20	20	240
Percent Capacity	105%	105%	105%	105%	100%	100%	100%	105%	105%	105%	105%	110%	104%

Residential Beds	5	4	7	7	7	9	9	9	9	9	9	9	93
Inpatient Beds	10	10	10	10	10	10	10	10	10	10	10	10	120
Percent Capacity	50%	40%	70%	70%	70%	90%	90%	90%	90%	90%	90%	90%	78%

2007					YTD
Inpatient Census	22	21	21	21	85
Inpatient Beds	20	20	20	20	80
Percent Capacity	110%	105%	105%	105%	106%

Residential Beds	9	9	10	9	37
Inpatient Beds	10	10	10	10	40
Percent Capacity	90%	90%	100%	90%	93%

Exhibit 4

Hospice and Palliative Care Center of Forsyth

Adverse Impact Calculation

		2005	2006	Average
A	Annual Number Patients on Waiting List	372	316	344
B	Average Length of Stay	12	12	12
C	Potential Day of Care for Waiting List (Row A*Row B)	4,464	3,792	4,128
D	Average Charge Per Inpatient Day (room+board + ancillary)			$ 4,000
E	Average Charge Per Hospice Inpatient Day			$ 600
F	Difference			$ 3,400
G	Excess Cost in Absence of Hospice Beds			$ 14,035,200
H	Number of Patients by Medically Underserved Group			
	Medicaid		6%	21
	Medicare		78%	268
	Indigent/Self-Pay		4%	14
	Commercial		12%	41
				344

Source: Average Charge per Inpatient day based on recent Forsyth County CON applications
G-7691-06 Kernersville Hospital, Forsyth Medical Center/Novant
G-7604-06 North Carolina Baptist Hospital Tower

Asheville PH
July 13, 2007

PETITION TO THE STATE HEALTH COORDINATING COUNCIL TO ADJUST THE 2008 STATE MEDICAL FACILITIES PLAN'S NEED DETERMINATION FOR HOSPICE INPATIENT BEDS FOR FORSYTH COUNTY

Hospice Inpath Beds + 10 addition hospice res

2008 DRAFT SMFP PUBLIC HEARING PRESENTATION

Good afternoon. My name is JoAnn Davis, President of the Hospice & Palliative Care Center (hereafter HPCC). We are a comprehensive center that provides support, guidance, palliative and hospice care to patients and their loved ones on every step of the path from serious illness to end of life care. One of the most rewarding aspects of our work is that we provide services to the entire family. HPCC, founded in 1979, was the first hospice in North Carolina. Since then, HPCC has grown to four offices located in Winston-Salem, Mocksville, Walnut Cove, and Salisbury to serve patients and their families from 13 counties.

I am here today to petition the State Health Coordinating Council (SHCC) to adjust the 2008 State Medical Facilities Plan to allow for a regional adjustment for ten (10) additional hospice inpatient beds and ten (10) additional hospice residential beds in Forsyth County. We will provide our complete petition by the August 1, 2007 deadline but I have traveled here today to provide you with an overview of the rationale for our petition.

HPCC is currently licensed for twenty (20) hospice inpatient beds at its Kate B. Reynolds Hospice Home and ten (10) hospice residential beds. All thirty (30) beds are built to the hospice inpatient standards and are located facilities that are physically connected.

As we will detail in our petition, HPCC has a full complement of medical directors and other clinical staff and we serve as a training site for residents from Wake Forest University School of Medicine. In most cases, the only element that prevents us from providing hospice care to more than twenty inpatients and ten residential hospice patients at our facility at any given time is the actual license for beds.

I want to take a moment to note that we support the state need methodology for hospice inpatient beds across the state. However, the situation in Forsyth County poses a unique challenge because the demand for hospice has pushed the existing facility beyond capacity. The central underlying reason that the state methodology does not recognize the need soon enough for Forsyth County is the fact that HPCC in Forsyth County serves patients from a metropolitan service area that includes patients from many of the outlying counties. The SHCC methodology recognizes each of the 100 counties as a separate service area. In practice, HPCC in Forsyth County serves a 13 county service area and 29% of our hospice inpatient and 22% of our hospice residential patients' homes are outside of Forsyth County. **In most cases, the patients who come from outside the county prefer to be served by HPCC because of the expanded services, and because they have sought specialty care at the medical centers in Forsyth County. In addition the medical services staff at HPCC is board certified in Hospice and Palliative Care, and therefore the best Hospice has to offer.**

As the volume of demand for hospice at HPCC continues to grow, we find ourselves increasingly operating above capacity. When all of the current hospice inpatient and hospice

NOTE: These are our public hearing presentation summary remarks. The detailed petition will be submitted at the August 1, 2007 hearing in Raleigh.

residential beds are full, HPCC finds itself in the unpleasant position of reducing or restricting access. As a result, we are concerned that without the additional requested beds, we will not be able to continue to offer potential patients the most cost-efficient setting for end of life care.

The HPCC in Forsyth County has developed two alternative scenarios to support the additional need for hospice inpatient beds, which will be presented in the petition.

- The first scenario adjusts the 2012 SMFP need for each of the counties where HPCC has historically drawn patients by applying the percentage of patient origin for those counties to the 2008 Draft SMFP need determination. This adjustment results in the need for 27 hospice inpatient beds.

- The second scenario converts the historical number of patients on the waiting list that were never admitted to HPCC in Forsyth County to days of care using the historical average length of stay. When this methodology was averaged over the past two years, the adjustment results in the need for 31 hospice inpatient beds.

While Hospice residential does not have an official SMFP need methodology, we have found in our experience that in order to provide a full continuum of Hospice options it is necessary to have a near 2:1 ratio of hospice inpatient:hospice residential beds. Medicare's respite benefit requires that care be provided in a licensed bed.

I would like to highlight just a few of the many elements that will support our request in the written petition in the **context of access, then quality and finally cost efficiency:**

Access:

- In 2006, at least ***269 patients died while waiting for a bed*** at HPCC in Forsyth County.
- The ***occupancy rate of hospice inpatient beds was 106 %*** in the first four months of 2007 and ***104%*** in 2006. In two of the last five months, the occupancy rate has been ***110%***.
- The occupancy rate of hospice residential beds was ***93%*** in the first four months of 2007. In one of the past five months, the occupancy rate was 100%.
- The occupancy rates greater than 100% underscore a critical strain on the capacity of hospice beds. The days in excess of 100% are only possible because ***multiple patients have died in the same room on the same day***. This is a quality indicator of a missed opportunity to offer a patient and their family more time in hospice. There were 367 days in 2006 and 156 days year to date in 2007 (through May) when more than one patient used the same bed on the same day.
- We serve a growing number of pediatric patients. The ***pediatric daily census has nearly doubled*** year to date 2007 over 2006.
- The ***vast majority of HPCC patients are from medically underserved populations.*** Medicare patients make up 78% and Medicaid 6% of the payer mix. Indigent and self-pay consists of an additional 4% of patients.
- The State methodology does not consider the ***growing undocumented alien population***. Forsyth County has one of the fastest growing populations of undocumented alien residents in the State of North Carolina.

NOTE: These are our public hearing presentation summary remarks. The detailed petition will be submitted at the August 1, 2007 hearing in Raleigh.

- As other providers in Forsyth County face capacity constraints, the demand for hospice is directly impacted. ***Both hospitals in Forsyth County are operating near capacity and there is a 198 bed deficit of nursing home beds in Forsyth County.***
- The ***population over 65 in Forsyth County is expected to grow 12%*** in the next five years.[1]

During periods where the hospice inpatient beds are full and hospice residential patients who require hospice inpatient care cannot be transferred, a subsequent access challenge is created for incoming hospice home care patients. ***Patients that are already in our hospice home care service who are in crisis (their condition reaches a point where they cannot safely be cared for in the home setting) can be denied admission to hospice inpatient when the beds are full.*** This can result in the patient's admission to an acute care hospital or nursing home even though they could have been treated in a hospice inpatient unit had a bed been available.

Quality:

In addition to the improved atmosphere and quality of life for patients during the end of life phase, a recent retrospective analysis just published in the Journal of Pain and Symptom Management found that ***mean survival was 29 days longer for hospice patients*** than for nonhospice patients.

The HPCC staffs both its hospice inpatient and hospice residential beds with a 24 hour multidisciplinary team. A physician is available on-call to respond to the needs of patients and engage in joint planning with the primary care physician. Since these staff are already in place, we can offer hospice inpatient services to all 30 beds if we were licensed for 30 hospice inpatient beds. Only a moderate amount of incremental operational clinical staff would be required to increase from 10 to 20 hospice residential beds. ***Without the additional beds, our services are capped at 30 total beds and other potential patients will have to be denied access in the future, not because we don't have the clinical competency and staffing in place but solely because of a licensing restriction.***

Cost efficiency:

Studies of hospice care in the clinical literature are increasingly recognizing hospice is a more cost-effective setting than an inpatient hospital for end of life care. In a recent retrospective review of patients who expired with ovarian cancer, ***the cost of care was much lower in the hospice group at $15,164 per patient as compared to $59,319 per patient in the non hospice group***.(1)

At HPCC the reimbursement from Medicare and private payers is $600 per day for hospice inpatient and $125 for hospice residential patients. These costs can be several thousand dollars lower than the costs patients might incur if they remained in inpatient acute care or a nursing home. The last few days of care for patients that die in an inpatient hospital or a nursing home are widely acknowledged to be the most costly days of the patients' admission.

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[1] Population Projection by Age Group Tables, North Carolina State Demographer, www.demog.state.nc.us, accessed June 19, 2007, 2012 estimate of 47,292, 2007 estimate of 42,244.

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Finally, 10 of the incremental inpatient beds can be immediately put in service in the existing physical plant. The ten requested residential beds will be added to our existing 10 residential bed complement in order to construct a new 20 bed residential unit. In our experience, it is not cost efficient to undertake a new project for less than 20 beds. In addition, we expect to raise the majority of the capital funds through a capital campaign which will introduce the residential beds in n extremely cost-efficient manner.

Adverse Effects on the Population If the Adjustment is Not Made

Without the requested additional hospice inpatient and hospice residential beds, patients who are at the end of life who have made the hard choice of moving into hospice may continue to be placed on a waiting list, or worse, denied access to HPCC.

Patients that are without any other support system to experience death with dignity in the home will not be afforded the opportunity at HPCC. Patients that are economically disadvantaged that cannot afford alternative settings to HPCC may be forced to seek care in a hospital or nursing home and incur costs that far outweigh the patient's resources.

The costs to the community for the patients that remain on the waiting list will continue to fester and grow higher than they would if the patients could be granted immediate access to the lower cost hospice setting. In addition, the operating costs will continue to escalate and cost inefficiencies will continue for HPCC as we attempt to manage patients in multiple settings (including the hospital based units) and we have to staff overtime to meet the demands of operating a unit at more than 100% capacity.

Finally, HPCC staff will be increasingly challenged to perform the continuous quality improvement efforts when we face sustained capacity overload in the patient care arena.

No Feasible Alternatives

HPCC considered several alternatives including: 1) status quo, 2) referring patients to hospice programs in the service area and 3) this petition.

The Status Quo is not acceptable to HPCC because access will continue to be denied to patients and their providers who are reaching out for our services at the time of greatest need for the patient. The Status Quo means as many as 316 patients may be left on the waiting list again this year and perhaps more in the future.

Referring patients to counties other than Forsyth, even when the patient is not from Forsyth is not practical. Most of the patients that we receive from other counties have been referred to HPCC because of our expanded services, expertise, and excellent care. They have already come to Winston-Salem for treatment at one of the referral medical centers. When the patient makes the choice for Hospice, they often want to remain in care that is delivered in collaboration with their specialist who is usually based in Winston-Salem.

NOTE: These are our public hearing presentation summary remarks. The detailed petition will be submitted at the August 1, 2007 hearing in Raleigh.

This petition is the only alternative that will allow HPCC to meet the current and future demand for high quality Hospice & Palliative Care services in a cost-effective manner.

The Requested Adjustment Will Not Unnecessarily Duplicate Health Services

HPCC is the only regional hospice program in the area and the oldest hospice program in North Carolina. Other local hospice programs in our service area can continue to meet the needs of their populations and will remain well utilized even if we are granted the opportunity for additional hospice inpatient and hospice residential beds.

HPCC is the only hospice program in the State and one of the few in the United States that enjoys the complete support of both area regional referral centers and both are in support of this petition.

Conclusion

For all the foregoing reasons, we strongly encourage the SHCC to consider carefully the petition presented by HPCC and determine there is a need for ten (10) additional hospice inpatient beds and ten (10) additional hospice residential beds in Forsyth County.

Thank you for your time and attention and I would be happy to answer any questions or provide additional information on any of my remarks.

JoAnn Davis
President

101 Hospice Lane
Winston-Salem, NC 27103
Telephone: (336) 768-3972

Exhibits:

1. Letters of Support
2. Adjusted Need Scenario Projections
3. Historical Occupancy Rate 2006 & Year to Date 2007

Reference List

(1) Lewin SN, Buttin BM, Powell MA, Gibb RK, Rader JS, Mutch DG et al. Resource utilization for ovarian cancer patients at the end of life: how much is too much? Gynecol Oncol. 2005;99:261-66.

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Hospice
Charlotte PH
7-25-07

PETITION TO THE STATE HEALTH COORDINATING COUNCIL TO ADJUST THE 2008 STATE MEDICAL FACILITIES PLAN'S NEED DETERMINATION FOR HOSPICE INPATIENT BEDS FOR FORSYTH COUNTY

2008 DRAFT SMFP PUBLIC HEARING PRESENTATION

Good afternoon. My name is JoAnn Davis, President of the Hospice & Palliative Care Center (hereafter HPCC). We are a comprehensive center that provides support, guidance, palliative and hospice care to patients. HPCC, founded in 1979, was the first hospice in North Carolina. Since our beginning, our philosophy has been that when Hospice care is appropriate and desired by the patient and family, it is the most cost-efficient setting for end of life care.

I am here today to petition the State Health Coordinating Council (SHCC) to adjust the 2008 State Medical Facilities Plan to allow for a regional adjustment for ten (10) additional hospice inpatient beds and ten (10) additional hospice residential beds in Forsyth County. In our petition we will provide the methodology used to project the need for the requested beds.

HPCC is currently licensed for twenty (20) hospice inpatient beds at its Kate B. Reynolds Hospice Home and ten (10) hospice residential beds. All thirty (30) beds are built to the hospice inpatient standards and are located facilities that are physically connected. **We are the only provider of hospice care in Forsyth County and our board consists of leaders from both major health systems who are in full support of this petition.**

We support the state need methodology for hospice inpatient beds across the state. However, the situation in Forsyth County poses a unique challenge because the demand for hospice has pushed the existing facility beyond capacity. The central underlying reason that the state methodology does not recognize the need soon enough for Forsyth County is the fact that HPCC in Forsyth County serves patients from a metropolitan service area that includes patients from many of the outlying counties. **In most cases, the patients who come from outside the county choose to stay in Forsyth County so they can remain under the care of specialists that live and work in Forsyth County.**

I would like to highlight just a few of the many elements that will support our request in the written petition:

Access:

- In 2006, at least ***269 patients who were candidates for hospice died while waiting for a bed*** at HPCC in Forsyth County.
- The ***occupancy rate of hospice inpatient beds was 106 %*** in the first four months of 2007 and ***104%*** in 2006. In two of the last five months, the occupancy rate has been ***110%***.
- The occupancy rates greater than 100% underscore a critical strain on the capacity of hospice beds. The days in excess of 100% are only possible because ***multiple patients have died in***

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the same room on the same day. There were 367 days in 2006 and 156 days year to date in 2007 (through May) when more than one patient used the same bed on the same day.

- The occupancy rate of hospice residential beds was ***93%*** in the first four months of 2007. In one of the past five months, the occupancy rate was 100%.
- We serve a growing number of pediatric patients. The ***pediatric daily census has nearly doubled*** year to date 2007 over 2006.
- The ***vast majority of HPCC patients are from medically underserved populations.*** *Medicare patients make up 78% and Medicaid 6% of the payer mix. Indigent and self-pay consists of an additional 4% of patients.*
- The State methodology does not consider the ***growing undocumented alien population***. Forsyth County has one of the fastest growing populations of undocumented alien residents in the State of North Carolina.
- As other providers in Forsyth County face capacity constraints, the demand for hospice is directly impacted. ***Both hospitals in Forsyth County are operating near capacity and there is a 198 bed deficit of nursing home beds in Forsyth County***.
- During periods where the hospice inpatient beds are full, patients that are already in our hospice home care service who are in crisis *(their condition reaches a point where they cannot safely be cared for in the home setting)* can be denied admission to hospice inpatient when the beds are full. This can result in the patient's admission to an acute care hospital or nursing home even though they could have been treated in a hospice inpatient unit had a bed been available.

Quality:

- A recent study just published in the Journal of Pain and Symptom Management found that ***mean survival was 29 days longer for hospice patients*** than for nonhospice patients.
- The HPCC staffs both its hospice inpatient and hospice residential beds with a 24 hour multidisciplinary team. Without the additional beds, our services are capped at 30 total beds and other potential patients will have to be denied access in the future, not because we don't have the clinical competency and staffing in place but solely because of a licensing restriction.

Cost efficiency:

- Studies of hospice care in the clinical literature what many of us have known since the beginning of the hospice movement - hospice is a more cost-effective setting than an inpatient hospital for end of life care. In a recent retrospective study, ***the cost of care was much lower in the hospice group at $15,164 per patient as compared to $59,319 per patient in the non hospice group***.(1)
- ***At HPCC the reimbursement from Medicare and private payers is $600 per day for hospice inpatient and $125 for hospice residential patients. These costs can be several thousand***

NOTE: These are our public hearing presentation summary remarks. The detailed petition will be submitted at the August 1, 2007 hearing in Raleigh.

dollars lower than the costs patients might incur if they remained in inpatient acute care or a nursing home.

- We expect to raise the majority of the capital funds through a capital campaign which will introduce the residential beds in an extremely cost-efficient manner.
- Finally, 10 of the incremental inpatient beds can be immediately put in service in the existing physical plant. The ten requested residential beds will be added to our existing 10 residential bed complement in order to construct a new 20 bed residential unit. **In our experience, it is not cost efficient to undertake a new project for less than 20 beds.**

Adverse Effects on the Population If the Adjustment is Not Made

- Without the requested additional hospice inpatient and hospice residential beds, patients who are at the end of life who have made the hard choice of moving into hospice may continue to be placed on a waiting list, or worse, denied access to HPCC.

- The costs to the community for the patients that remain on the waiting list will continue to grow higher than they would if the patients could be granted immediate access to the lower cost hospice setting.

- Finally, HPCC staff will be increasingly challenged to perform the continuous quality improvement efforts when we face sustained capacity overload in the patient care arena.

No Feasible Alternatives

- The Status Quo means as many as 316 patients may be left on the waiting list again this year and perhaps more in the future.

- Referring patients to counties other than Forsyth, even when the patient is not from Forsyth is not practical. Most of the patients that we receive from other counties have been referred to HPCC because they have already come to Winston-Salem for treatment at one of the referral medical centers. When the patient makes the choice for Hospice, they often want to remain in care that is delivered in collaboration with their specialist who is based in Winston-Salem.

The Requested Adjustment Will Not Unnecessarily Duplicate Health Services

- As we noted in the opening, HPCC is the only hospice program in the State and one of the few in the United States that enjoys the complete support of both area regional referral centers and both are in support of this petition.

- We support the additional hospice beds in our service area that are under development as they will help answer growing community need however, the approved beds will not address the needs of patients who seek our services to remain under the care of specialists based in Winston-Salem.

NOTE. These are our public hearing presentation summary remarks. The detailed petition will be submitted at the August 1, 2007 hearing in Raleigh.

Conclusion

For all the foregoing reasons, we strongly encourage the SHCC to consider carefully the petition presented by HPCC and determine there is a need for ten (10) additional hospice inpatient beds and ten (10) additional hospice residential beds in Forsyth County.

Thank you for your time and attention and I would be happy to answer any questions or provide additional information on any of my remarks.

JoAnn Davis
President

101 Hospice Lane
Winston-Salem, NC 27103
Telephone: (336) 768-3972

Reference List

(1) Lewin SN, Buttin BM, Powell MA, Gibb RK, Rader JS, Mutch DG et al. Resource utilization for ovarian cancer patients at the end of life: how much is too much? Gynecol Oncol. 2005;99:261-66.

NOTE: These are our public hearing presentation summary remarks. The detailed petition will be submitted at the August 1, 2007 hearing in Raleigh.

Hospice & Palliative Care Center Petition to the State Health Coordinating Council to adjust the 2008 State Medical Facilities Plan Need Determination for Hospice Beds for Forsyth County

2008 DRAFT SMFP Public Hearing Presentation
August 1, 2007

Good afternoon. My name is JoAnn Davis, President of the Hospice & Palliative Care Center (hereafter HPCC). We are a comprehensive center that provides support, guidance, palliative and hospice care to patients. HPCC, founded in 1979, was the first hospice in North Carolina. Since our beginning, our philosophy has been that when Hospice care is appropriate and desired by the patient and family, it is the most cost-efficient setting for end of life care.

I am here today to petition the State Health Coordinating Council (SHCC) to adjust the 2008 State Medical Facilities Plan to allow for a regional adjustment for ten (10) additional hospice inpatient beds and ten (10) additional hospice residential beds in Forsyth County. In our petition we will provide the methodology used to project the need for the requested beds.

HPCC is currently licensed for twenty (20) hospice inpatient beds at its Kate B. Reynolds Hospice Home and ten (10) hospice residential beds. All thirty (30) beds are built to the hospice inpatient standards and are located in facilities that are physically connected. **We are the only provider of hospice care in Forsyth County and our board consists of leaders from both major health systems who are in full support of this petition.**

We support the state need methodology for hospice inpatient beds across the state. However, the situation in Forsyth County poses a unique challenge because the demand for hospice has pushed the existing facility beyond capacity. The central reason that the state methodology does not recognize the need soon enough for Forsyth County is the fact that HPCC in Forsyth County serves patients from a metropolitan service area that includes patients from many of the outlying counties. **In most cases, the patients who come from outside the county choose to stay in Forsyth County so they can remain under the care of specialists that live and work in Forsyth County.**

I would like to highlight just a few of the many elements that will support our request in the written petition:

Access:

- In 2006, at least ***269 patients who were candidates for the Kate B. Reynolds Hospice Home died while waiting for a bed***
- The ***occupancy rate of hospice inpatient beds was 106 %*** in the first four months of 2007 and ***104%*** in 2006. In two of the last five months, the occupancy rate has been ***110%***.
- The occupancy rates greater than 100% underscore a critical strain on the capacity of hospice beds. The days in excess of 100% are only possible because ***multiple patients were in the***

NOTE: These are our public hearing presentation summary remarks. The detailed petition will be submitted by the August 3, 2007 deadline.

same room on the same day. There were 367 days in 2006 when more than one patient used the same bed on the same day.

- The occupancy rate of hospice residential beds was ***93%*** in the first four months of 2007. In one of the past five months, the occupancy rate was 100%.
- We serve a growing number of pediatric patients. The ***pediatric daily census has nearly doubled*** year to date 2007 over 2006.
- The ***vast majority of HPCC patients are from medically underserved populations.*** *Medicare patients make up 78% and Medicaid 6% of the payer mix Indigent and self pay consists of an additional 4% of patients.*
- The State methodology does not consider the ***growing undocumented immigrant population***. Forsyth County has one of the fastest growing populations of undocumented immigrant residents in the State of North Carolina.
- As other providers in Forsyth County face capacity constraints, the demand for hospice is directly impacted. ***Both hospitals in Forsyth County are operating near capacity and there is a 198 bed deficit of nursing home beds in Forsyth County***.
- During periods where the hospice inpatient beds are full, patients that are already in our hospice home care service who are in crisis *(their condition reaches a point where they cannot safely be cared for in the home setting)* can be denied admission to hospice inpatient when the beds are full. This can result in the patient's admission to an acute care hospital or nursing home even though they could have been treated in a hospice inpatient unit had a bed been available.

Quality:

- HPCC offers a ***full speetrum of end-of-life services and advanced levels of clinical staffing*** that patients and their providers expect after transfer from our area's medical facilities with a regional focus.
- Hospice is not only a more pleasant setting for end of life services, but it may also extend quality of life. A recent study just published in the Journal of Pain and Symptom Management found that ***mean survival was 29 days longer for hospice patients*** than for nonhospice patients.
- Without the additional beds, our services are capped at 30 total beds and other potential patients will have to be denied access in the future, not because we don't have the clinical competency and staffing in place but solely because of a licensing restriction.

Cost efficiency:

- ***At HPCC the charge to Medicare and private payers is $600 per day for hospice inpatient and $140 for hospice residential patients. These charges can be several thousand dollars lower than the costs patients might incur if they remained in inpatient acute care or a nursing home***.

NOTE. These are our public hearing presentation summary remarks. The detailed petition will be submitted by the August 3, 2007 deadline.

- ***The proposed beds will allow us to help save at least $14 million annually in medical costs in our own service area***[1] if patients that are already on our waiting list and appropriate hospice candidates can be seen by HPCC rather in a hospital setting.
- The ten (10) of the incremental inpatient beds can be immediately put in service in the existing physical plant with ***no capital cost*** to the health care system.
- The ten requested residential beds will be added to our existing ten (10) residential bed complement in order to construct a new 20 bed residential unit. We expect to raise the capital funds through a ***capital campaign which will introduce the residential beds in an extremely cost-efficient manner***. In our experience, it is not cost efficient to undertake a new project for less than 20 beds.

Adverse Effects on the Population If the Adjustment is Not Made

- Without the requested additional hospice inpatient and hospice residential beds, patients who are at the end of life who have made the hard choice of moving into hospice may continue to be placed on a waiting list, or worse, denied access to HPCC.

- The costs to the community for the patients that remain on the waiting list will continue to be $14 million or higher than they would if the patients could be granted immediate access to the lower cost hospice setting.

- HPCC staff will be increasingly challenged to perform the continuous quality improvement efforts when we face sustained capacity overload in the patient care arena.

No Feasible Alternatives

- The Status Quo means at least 316 patients may be left on the waiting list again this year and perhaps more in the future.

- Referring patients to counties other than Forsyth, even when the patient is not from Forsyth is not practical. Most of the patients that we receive from other counties have been referred to HPCC because they have already come to Winston-Salem for treatment at one of the referral medical centers. When the patient makes the choice for Hospice, they often want to remain in care that is delivered in collaboration with their specialist who is based in Winston-Salem.

The Requested Adjustment Will Not Unnecessarily Duplicate Health Services

- As we noted in the opening, HPCC is the only hospice program in the State and one of the few in the United States that enjoys the complete support of both area regional referral centers and both are in support of this petition.

---

[1] Calculation methodology provided in the formal petition

NOTE: These are our public hearing presentation summary remarks. The detailed petition will be submitted by the August 3, 2007 deadline.

- We support the additional hospice beds in our service area that are under development as they will help answer growing community need however, the approved beds will not address the needs of patients who seek our services to remain under the care of specialists based in Winston-Salem.

Conclusion

For all the foregoing reasons, we strongly encourage the SHCC to consider carefully the petition presented by HPCC and determine there is a need for ten (10) additional hospice inpatient beds and ten (10) additional hospice residential beds in Forsyth County.

Thank you for your time and attention and I would be happy to answer any questions or provide additional information on any of my remarks.

JoAnn Davis
President

101 Hospice Lane
Winston-Salem, NC 27103
Telephone: (336) 768-3972

NOTE. These are our public hearing presentation summary remarks. The detailed petition will be submitted by the August 3, 2007 deadline.

Executive Summary

Petition: Adjustment for ten (10) additional hospice inpatient beds and ten (10) additional hospice residential beds in Forsyth County

Current bed complement:	**Needed bed complement:**
20 Hospice IP Beds	30 Hospice IP Beds
10 Hospice Residential Beds	20 Hospice Residential Beds

Need Methodology:
Scenario 1: Patient Origin*SMFP need by county=25 Hospice IP Beds
Scenario 2: Number Patients Denied Access*ALOS=31 Hospice IP Beds
Residential: 1.5:1 ratio of Hospice IP:Residential–20 Hospice Residential Beds

Rationale:	
Access	• In 2006, at least 269 patients who were candidates for the Kate B. Reynolds Hospice Home died while waiting for a bed • In 2006, on 367 days, more than one person died in a Hospice IP room • Hospice IP occupancy rate is currently 104-110% and residential is 93% • Both hospitals in Forsyth County are operating near capacity and there is a 198 bed deficit of nursing home beds in Forsyth County

Cost	• The proposed beds will save $14 million annually in medical costs
	• No cost to the health care system:
	  o The ten inpatient beds can be added at zero cost
	  o The residential beds will be funded by a capital campaign

Quality	• HPCC is staffed with a multidisciplinary team of full-time medical directors, residents, nursing and paramedical professionals • HPCC offers a full continuum of end-of-life services to patients and their families that is greatly valued by the specialists in Winston-Salem that continue to refer patients to HPCC • Hospice patients can have a longer lifespan than patients treated in a hospital setting

Adverse effects to service area if not approved:

- At least $14 million in medical costs will be incurred annually as patients are admitted to hospitals rather than hospice inpatient beds
- 268 Medicare, 21 Medicaid, 14 Indigent/Self-Pay and 41 Commercial (344 total) patients annually will not have access to hospice services each year

Not Duplicative:

- HPCC asks for these beds in order to maintain the level of service *presently demanded* by residents and physicians of Forsyth and contiguous counties.
- HPCC will continue to complement rather than compete with the services available in the counties contiguous to Forsyth

NOTE: These are our public hearing presentation summary remarks. The detailed petition will be submitted by the August 3, 2007 deadline.

Hospice & Palliative
CARECENTER

101 Hospice Lane • Winston-Salem, NC 27103 • ph: 336.768.3972 • fax: 336.650.0461

September 4, 2007

Mr. Floyd Cogley, Planner
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

RE: **Additional Support and Information for**
Hospice & Palliative Care Center Petition to adjust the 2008 State Medical Facilities Plan Need Determination for Hospice Beds in Forsyth County

Dear Mr. Cogley,

I am pleased to pass on several letters of support for our petition from other area hospice programs. These letters demonstrate that our colleagues in other hospice programs understand the nature of our regional mission and support our efforts to continue to serve the patients who seek our services.

We are very excited about the opportunity to extend access by providing additional beds and service to our community. Our donors have expressed a great interest in this project and we are gearing up for a capital campaign that will provide the funds for the additional residential space.

In addition, after further discussion of our petition with you, members of the committee and other area hospice programs, I would like to provide some clarifying information. Note that this information is not intended to replace or amend our original petition; rather this information is intended to clarify what we have previously submitted:

1. The patient origin by county of the 269 people on the waiting list is provided in Exhibit 1 to this memorandum. The distribution across counties is very similar to the patient origin we provided in Exhibit 1 of the Petition.
2. Of the 70 Davidson County residents that our KBR Hospice Home served in 2006, only 7 were Hospice of Davidson County contracted patients. The rest were either our home care patients or direct admits into our program from the hospital. We certainly expect the contracted days to shift back to the new Davidson facility, once it is completed, however we do not expect those days to have a significant impact on our waiting list.

3. It has come to our attention that the historical service share of Surry and Davidson was incorrectly quoted as 12.4% and 17.4% respectively on the petition. The correct historic service share based on information in the 2008 SMFP is as quoted in Exhibit 1 of 1.9% and 21.6% respectively.

Thank you in advance for accepting these materials and forwarding to the members of the Long-Term Care and Behavioral Health Committee. Members of my senior leadership team will be at the September 14th meeting and prepared to comment on any questions that may arise.

Please do not hesitate to contact me for additional information. I look forward to the opportunity to support this petition further during the review process.

Sincerely,

JoAnn Davis
President & CEO

Enclosures:
Exhibits
Letters of Support

2006 KBR waitlist

269 total died on KBR waitlist

Forsyth	174	65.0%
Davie	13	4.8%
Davidson	18	6.7%
Stokes	14	5.2%
Surry	11	4.1%
Yadkin	9	3.3%
Rowan	2	0.7%
Guilford	8	3.0%
Wilkes	6	2.2%
Other	10	3.7%
VA	4	1.5%

2006 daily average on waitlist 6.31

2007 KBR Waitlist
Jan- July

Total YTD 111

Forsyth	70	63.1%
Davie	9	8.1%
Davidson	11	9.9%
Stokes	7	6.3%
Surry	2	1.8%
Yadkin	1	0.9%
Rowan	1	0.9%
Guilford	6	5.4%
Wilkes	2	1.8%
Other	2	1.8%
VA	0	0.0%

YTD daily average on waitlist-7.1

HOSPICE
of RANDOLPH COUNTY
-Est. 1981-

Accredited by the Accreditation Commission for Health Care, Inc.

Hospice Care • Home Health Care • Grief Support • Kids Path® Pediatric Care & Grief Support
Caterpillar's Quest Child Grief Camp • Nursing Home & Assisted Living Facility Services
Advanced Care Planning • Internship Site for Nursing & Social Work Students

August 28, 2007

Mr. Floyd Cogley, Planner
Medical Facilities Planning Section
Division of Facility Services

Mr. Cogley:

We acknowledge that the Kate B. Reynolds Hospice Home in Winston-Salem has been instrumental in helping maximize the care (while minimizing health care costs) to terminal patients in and around Forsyth County. We have worked together for many years in providing the best possible care for patients and families regardless of physical location. The additional beds in Forsyth County will only add value to the service of all.

We support Hospice and Palliative CareCenter in their Special Needs Petition for additional beds at the Kate B. Reynolds Hospice Home.

Sincerely,

Rhonda L. Burch
CEO/President

cc: JoAnn Davis, President & CEO
Hospice & Palliative CareCenter

HOSPICE
of the PIEDMONT
the comfort of experience

August 27, 2007

Floyd Cogley
Medical Facilities Planner
Division of Facility Services

Dear Mr. Cogley,

We have worked in a collaborative relationship with the other hospices in the Triad including Hospice and Palliative Care Center in Winston-Salem (HPCC) for a number of years in order to best serve the end of life care needs of our citizens. We appreciate their assistance in helping us develop our facility in High Point.

We understand that HPCC is requesting a special petition to create 10 additional general inpatient beds at the Kate B. Reynolds Home due to the number of patients on their waiting list who could not otherwise be served. While we are not in a position to comment on this specific need, we are not opposed to their request.

Sincerely,

Leslie Kalinowski

Leslie Kalinowski
CEO/president

1801 Westchester Drive • High Point, NC 27262 - 7009 • Fax 336.889.3450 • Phone 336.889.8440
www.hospice-careconnection.org

Hospice & Palliative
CARECENTER

1-A Hospice Lane • Winston-Salem, NC 27103 • ph. 336 768 3072 • fax 336 659-0461

September 4, 2007

Mr. Floyd Cogley, Planner
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Dear Floyd,

The following is a letter that we sent to members of the Long Term Care Committee:

I am writing to make an additional appeal for your careful consideration of the petition by Hospice & Palliative Care Center in Forsyth County (HPCC) to add 10 Hospice inpatient beds to the 2008 SMFP and allow the development of 10 additional residential beds. As you review our detailed petition, we ask for your continued focus on the following themes:

1. HPCC has the opportunity to expand access to hospice services in our service area at zero additional cost to the health care system. Our 10 residential beds can be converted to inpatient and we will build a new residential facility with funds from a capital campaign. As the oldest hospice in the state, our donor base is significant. Staffing is already in place for the inpatient beds and the residential will require only incremental staffing.

2. HPCC operates as a regional provider so need and demand in the county based methodology lags actual demand for our services. The 10 additional beds we ask for are justified by the unmet demand on our own waiting list. These are patients that have selected Hospice & Palliative Care Center as their provider and have been turned away solely because of a lack of licensed capacity. It is important to note that we serve an urban and a rural base. Three of our most significant rural counties, Davie, Stokes and Yadkin will not show a need for 6 beds for 10-28 years yet there is clearly a need for these counties which goes unmet as long as there is a need of 3, 4, and 2 beds respectively. This special need determination will allow for these counties to have additional capacity open to them until their need reaches the 6-bed threshold.

3. HPCC has obtained support from hospice programs in the contiguous counties and does not expect any opposition to this project. We will be submitting letters of support via Floyd Cogley's office from programs in the contiguous counties. Just as we have supported recent applications, the other providers understand our need is to serve our patient base and is not a duplication of existing capacity.

4. If there is even one patient who gets "waitlisted" for a hospice bed and ends up in a more expensive setting, then the health care system has failed. In the early days of Hospice, the burden was on hospice to show cost effectiveness and quality. Nearly 30 years later, there are numerous articles that document the cost effectiveness and quality of the hospice setting. As we documented in our petition, our existing unmet need is resulting in several million dollars of unnecessary costs associated with an acute care facility or long-term care settings for end of life.
At HPCC, we are uniquely poised with the existing demand for services, "know how" and clinical bench strength to expand at no cost to the health care system. The only thing that is hampering our mission to serve additional patients is the licensing restriction. The petition's approval will clear the way for us to pursue a CON and develop additional capacity.

Thank you in advance for your careful consideration of these underlying themes in our petition. The need for our petition is very real, the costs are non-existent and the opportunity to improve access to high quality end of life care is before us. While we support the need methodology, our regional nature compels us to pursue this petition with great interest.

Members of our senior leadership team will be in the audience of the September 14th meeting and we look forward to the opportunity to add any additional information or clarification if you call on us. Please do not hesitate to contact me in advance of the meeting for additional information. We look forward to the opportunity to continue to serve our communities and the patients and families who rely on us.

Sincerely,

Lisa Holleman

Lisa H. Holleman
Sr. Vice President, Strategic Development
Hospice & Palliative CareCenter

September 4, 2007

Mr. Floyd Cogley, Planner
Medical Facilities Planning Section
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

Dear Mr. Cogley:

Mountain Valley Hospice and Palliative Care acknowledges that the Kate B. Reynolds Hospice Home in Winston-Salem has been instrumental in meeting the needs of terminally patients in and around Forsyth County, however we oppose the approval of the special needs petition for more beds at this time.

Our opposition is based upon the impact expected once our hospice home facility in Surry County is completed in 2008 and those being constructed in surrounding counties. In addition, the 2008 State Medical Facilities Plan has determined there is no need for additional hospice inpatient beds in Forsyth County.

Currently, patients from counties adjacent to Forsyth County use the Kate B. Reynolds Hospice Home, however once the new facilities are constructed patients will have the option of using several facilities capable of meeting the needs of hospice facility care. Adding additional beds now will not add value but will risk the creation of occupancy issues.

Once the facilities currently under construction begin to serve patients, the need for additional beds should be re-evaluated to ensure the needs in our communities are being met.

In summary, Mountain Valley Hospice and Palliative Care opposes Hospice and Palliative Care's special needs petition for 10 inpatient and 10 residential beds at the Kate B. Reynolds Hospice Home.

Respectfully Submitted,

Denise Watson, RN, BSN

Denise Watson, RN, BSN
Executive Director
Mountain Valley Hospice and Palliative Care

Petition Inpatient Hospice – 3
Received Regarding Proposed 2008 State Medical Facilities Plan

Attached are:

1. Petition from Hospice of Gaston County

2. Written comment received.

Petition to State Health Coordinating Council

Adjustment to IP Hospice Bed Need Included in the Proposed 2008 State Medical Facilities Plan

July 25, 2007

Petitioner: Hospice of Gaston County d/b/a Gaston Hospice
258E Garrison Boulevard
Gastonia, NC 28054

Contact: Leona T. Bucci, Executive Director
258E Garrison Boulevard
Gastonia, NC 28054
(704) 861-8405

Statement of Requested Change

Petition

Gaston Hospice is submitting this petition to the State Health Coordinating Council requesting an adjustment to the need determination for IP hospice beds included in Chapter 13 of the Proposed 2008 State Medical Facilities Plan.

A deficit of 7 IP hospice beds is identified in Table 13C on page 284 and a need determination for 7 IP hospice beds is identified in Table 13E on page 290 in the Proposed 2008 State Medical Facilities Plan for Gaston County. Gaston Hospice is specifically requesting that the need for IP hospice beds in Gaston County be adjusted to a need determination for zero (0) IP hospice beds for the 2008 State Medical Facilities Plan.

Proposed IP Hospice Bed Need Adjustment Data and Information

On Sunday, July 22, Gaston Hospice celebrated the grand opening of its $6.5 million Hospice House, which includes 6 IP hospice beds and 6 residential hospice beds. The development of the Hospice House has been a community effort with 100% of the Hospice House's funding coming from a combination of public capital campaign events, foundation donations, and miscellaneous corporate and governmental grants. Because of the dramatic increase in construction costs immediately after Hurricane Katrina, the Hospice House was burdened with both delays in construction and having to file a cost overrun CON application; however, the Hospice House was still able to begin operation only 12-months behind schedule.

Gaston Hospice requests the IP hospice bed need determination adjustment for the following reasons:

- Gaston Hospice House, a new, combined IP and residential hospice facility, became operational on July 22; this new facility will meet the needs of Gaston County residents for IP hospice care for the foreseeable future. Adding additional beds will only serve to duplicate this newly operational resource, which is directly contrary to the purpose of the CON Law.
- The draft 2008 SMFP projects 4,067 IP hospice days of care, but the need methodology is incapable of determining what number of days can be accommodated in a residential hospice setting versus an IP hospice setting. Gaston Hospice's approved cost overrun CON application projected 4,200 combined IP

and residential hospice days of care, which is essentially equal to the need shown in the draft 2008 SMFP.

- Gaston Hospice provided 85.4% of Gaston County hospice days of care (41,386 / 48,469 = 85.4%) and cared to 88.1% of the Gaston County hospice patients who died in hospice care. As a result, no other hospice provider in Gaston County can generate the volume of days of care to meet the 1,660 days of care or 65% occupancy for a 7-bed facility, as required in §10A NCAC 14C .4003(A)(2). There are not enough hospice patients to support two IP hospice facilities in Gaston County. While the 7-bed facility might serve some patients who might otherwise go to Gaston Hospice, it is highly unlikely that it would serve enough patients that it would be fully utilized or be financially feasible. At the same time, a volume shift could cause the new Gaston Hospice facility to become underutilized. Gaston County does not need two underutilized hospice facilities. It makes more sense to allow the Gaston Hospice facility to operate for a period of time and then determine whether additional IP hospice beds are needed.
- The Long Term Care Committee previously approved IP hospice beds need adjustments in Columbus, Robeson, and Surry County primarily because these counties have new IP hospice facilities and secondarily because these counties had more hospice days of care per 1,000 population than the state average. Gaston County's situation is similar because a new facility recently opened, so the SHCC should treat this situation like those other three counties and adjust the need determination.

Gaston Hospice believes that a thorough analysis of the IP hospice bed need methodology must be completed before additional IP hospice beds can be appropriately determined for counties that have an existing IP hospice facility, IP hospice beds under construction, or approved IP hospice beds.

Summary

Gaston Hospice is requesting that the 7 IP hospice bed need determination in Gaston County identified in the Proposed 2008 State Medical Facilities Plan be adjusted to a need determination for zero (0) IP hospice beds for the 2008 State Medical Facilities Plan.

7-25-07
Hospice
Charlotte PH

Excerpts and summation of the Gaston Hospice Petition to State Health Coordinating Council

Gaston Hospice is submitting this petition to the State Health Coordinating Council requesting an adjustment to the need determination for IP hospice beds included in Chapter 13 of the Proposed 2008 State Medical Facilities Plan.

A deficit of 7 hospice IP beds is identified in Table 13C on page 284 and a need determination for 7 IP hospice beds is identified in Table 13E on page 290 in the Proposed 2008 State Medical Facilities Plan for Gaston County. Gaston Hospice is specifically requesting that the need for IP hospice beds in Gaston County be adjusted to a need determination of zero (0) IP hospice beds for the 2008 State Medical Facilities Plan.

Summation of reasons:

- On July 22, 2007 Gaston Hospice opened the Robin Johnson House, a new combined IP and residential hospice facility, with six (6) IP beds and six (6) residential beds. This new facility will meet the needs of Gaston County residents for IP hospice care for the foreseeable future. Adding additional beds will only serve to duplicate this newly operational resource, which is directly contrary to the purpose of the CON Law.

- Gaston Hospice's approved cost overrun CON application projected 4,200 combined IP and residential hospice days of care, which is essentially equal to the need projected in the 2008 SMFP draft.

- Gaston Hospice provided 85.4% of the Gaston County hospice days of care and served 88.1% of the Gaston County hospice patients who died in hospice care. As a result, no other hospice provider in Gaston County can generate the volume of days of care to meet the 1,660 days of care or 65% occupancy for a 7-bed facility, as required. There are not enough hospice patients to support two IP hospice facilities in Gaston County.

- An additional 7-bed facility might serve some patients who would otherwise go to Gaston Hospice. However, it is highly unlikely that another facility would serve enough patients to make it viable and may in fact cause both facilities to be underutilized.

- Previously, The Long Term Care Committee approved IP hospice bed need adjustments in Columbus, Robeson, and Surry Counties for similar reasons. (I.e. newly constructed hospice facilities)

- Gaston Hospice believes a thorough analysis of the IP hospice beds need methodology must factor in these new six (6) IP hospice beds and/or IP beds under construction, in order to truly assess and determine need.

Summary:

Gaston Hospice is requesting that the Seven (7) IP hospice bed need determination in Gaston County identified in the Proposed 2008 State Medical Facilities Plan be adjusted to a need determination for zero (0) IP hospice beds for 2008 State Medical Facilities Plan.

Petition Inpatient Hospice – 4
Received Regarding Proposed 2008 State Medical Facilities Plan

Attached are:

1. Petition from Haywood Regional Medical Center Hospice.

2. Written comment received.

PETITION

Petition for a Special Need Adjustment to the 2008 State Medical Facilities Plan For Haywood County

PETITIONER:

Home Care Services of Haywood Regional Medical Center
dba/ Haywood Regional Medical Center Hospice
560 Leroy George Drive
Clyde, NC 28721

Jenny C. Williams, Hospice Program Manager
Telephone: (828) 452-8292
Facsimile: (828) 452-7078

REQUESTED CHANGE:

Haywood Regional Medical Center Hospice requests an adjusted need determination to include three additional inpatient beds for a total need of six beds.

REASONS FOR CHANGE:

Our community's needs for Hospice are eminent. Haywood County's population continues to grow. In 2005, people over the age of 65 represented 20% or 11,000 of our community members. Projections for 2010 indicate that the number of people here over the age of 65 will increase to nearly 24%. Haywood County significantly exceeds the state's percentage of 12% and neighboring counties' rates of growth in the senior population.

Our increase in hospice care reflects population growth. Over the last five years, the number of patients HRMC Hospice served has risen 80%. During 2006, Hospice served 263 families, an increase of 22% from 2005. The substantial growth in patient and family care requires a strategy for dealing with our community's end-of-life care concerns.

In addition to the aging population, the needs and expectations of the people we serve indicate that dying at home is not priority for the majority. In 2006, 99% of patients served by HRMC died in the location of their choosing. And, 53% of those patients died in places other than home. 31% died in a hospital. This makes hospice inpatient care necessary. The advantages to patients receiving inpatient care in a hospice unit vs. other inpatient settings are evident.

- End-of-life care is the primary focus in a hospice unit which translates to staff training and care focused on palliation and counseling to this special group of people.
- A hospice inpatient unit is designed to be a homelike atmosphere to provide peace of mind for the patient and more comforting surroundings for family accommodation.
- Costs of running the facility reflect only hospice costs and quality assurance, services, and utilization review are controlled.

In 2004, our county received a grant to investigate the needs of the aging population. From the surveys and town hall meetings administered in each community, an inpatient hospice unit was ranked high in the top ten needs and creation of a hospice facility in Haywood County was clearly supported. Community members recognize that there is a facility in Buncombe County but the waiting list is long and the 40 to 60 minute drive one-way is unmanageable for the elderly. Patients often die before a bed becomes available and elderly spouses are restricted from visiting their loved ones because of their limited driving ability or availability of transportation. There are

no existing beds in the counties west and south of Haywood and projections indicate the need for ten additional beds in those counties.

We believe that in our county, the need for inpatient hospice beds cannot be based on total days of care alone. We request that you consider the needs and desires of Haywood County residents which includes the fact that almost one third choose not to die at home. In addition, our aging population rate is growing at a faster rate than the state average.

HRMC Hospice requests that the State Medical Facilities Planning Board increase the allocation of hospice beds in Haywood County to a total of six beds.

Thank you for your consideration.

Asheville PH
June 13, 2007
Hospice

COMMENTS ON THE PROPOSED 2008 STATE MEDICAL FACILITIES PLAN FOR HAYWOOD COUNTY

REQUESTOR:

Home Care Services of Haywood Regional Medical Center
dba/ Haywood Regional Medical Center Hospice
560 Leroy George Drive
Clyde, NC 28721

Jenny C. Williams, Hospice Program Manager
Telephone: (828) 452-8292
Facsimile: (828) 452-7078

REQUESTED CHANGE:

Haywood Regional Medical Center Hospice requests an adjusted need determination to include three additional inpatient beds for a total need of six beds.

REASONS FOR CHANGE:

The community needs for Hospice are eminent. Haywood County's population continues to grow. In 2005, people over the age of 65 represented 20% or 11,000 of our community members. Projections for 2010 indicate that the number of people here over the age of 65 will increase to nearly 24%. Haywood County significantly exceeds the state's percentage of 12% and neighboring counties' rates of growth in the senior population.

Our increase in hospice care reflects population growth. Over the last five years, the number of patients HRMC Hospice served has risen 80%. During 2006, Hospice served 263 families, an increase of 22% from 2005. The substantial growth in patient and family care requires a strategy for dealing with our community's end-of-life care concerns.

In addition to the aging population, the needs and expectations of the people we serve indicate that dying at home is not priority for the majority. In 2006, 99% of patients served by HRMC died in the location of their choosing. And, 53% of those patients died in places other than home. 31% died in a hospital. This makes hospice inpatient care necessary. The advantages to patients receiving inpatient care in a hospice unit vs. other inpatient settings are evident.

- End-of-life care is the primary focus in a hospice unit which translates to staff training and care focused on palliation and counseling to this special group of people.
- A hospice inpatient unit is designed to be a homelike atmosphere to provide peace of mind for the patient and more comforting surroundings for family accommodation.
- Costs of running the facility reflect only hospice costs and quality assurance, services, and utilization review are controlled.

In 2004, our county received a grant to investigate the needs of the aging population. From the surveys and town hall meetings administered in each community, an inpatient hospice unit was ranked high in the top ten needs and creation of a hospice facility in Haywood County was clearly supported. Community members recognize that there is a facility in Buncombe County but the waiting list is long and the 40 to 60 minute drive one-way is unmanageable for the elderly. Patients often die before a bed becomes available and elderly spouses are restricted from visiting their loved ones because of their limited driving ability or availability of transportation. There are no existing beds in the counties west and south of Haywood and projections indicate the need for ten additional beds in those counties.

We believe that in our county, the need for inpatient hospice beds cannot be based on total days of care alone. We request that you consider the needs and desires of Haywood County residents which includes the fact that almost one third choose not to die at home. In addition, our aging population rate is growing at a faster rate than the state average. HRMC Hospice urges the State Medical Facilities Planning Board to consider the future establishment of six inpatient beds for Hospice to meet these special needs.

Petition Inpatient Hospice – 5
Received Regarding Proposed 2008 State Medical Facilities Plan

Attached is the Petition from Johnston Memorial Hospital Authority.

PETITION

North Carolina State Health Coordinating Council

Submitted to:
Dr. Thomas Pulliam, Chair
Long-Term and Behavioral Health Committee
c/o Floyd Cogley, Planner
Medical Facilities Planning Section
Division of Facility Services
701 Barbour Drive
Raleigh, NC 27626

Submitted by:
Kevin Rogols
President and Chief Executive Officer
Johnston Memorial Hospital Authority
509 North Bright Leaf Boulevard
Smithfield, NC 27577
(910) 938-7114
krogols@johnstonmemorial.org

Executive Summary

Johnston Memorial Hospital (JMH) is committed to serving the health care needs of the citizens of Johnston County and the surrounding region, regardless of race, ethnicity, gender, age, or ability to pay. As part of its service to the community, JMH provides a variety of high quality health-related services, including the operation of a separately licensed hospice home care agency, Johnston Memorial Home Care and Hospice. In 2006, under the *2006 State Medical Facilities Plan*, JMH applied for, and was awarded a certificate of need to develop a 12-bed combination hospice facility with eight inpatient beds and four residential beds in Johnston County. This facility is scheduled to become operational in mid 2009. The Proposed *2008 State Medical Facilities Plan* includes a need determination for eight additional hospice inpatient beds in Johnston County, for a total need determination of 16 hospice inpatient beds in Johnston County since 2006.

JMH believes the need for hospice inpatient beds in Johnston County is overstated in the Proposed *2008 State Medical Facilities Plan*. To address this concern, JMH requests an adjusted hospice inpatient bed need determination in the *2008 State Medical Facilities Plan* of four (4) rather than eight (8) hospice inpatient beds.

Requested Change

JMH requests an adjusted need determination in the *2008 State Medical Facilities Plan* of four (4) hospice inpatient beds rather than eight (8) beds.

Reason for Request

JMH believes that the current methodology used to determine the need for additional hospice inpatient beds in the *State Medical Facilities Plan* is a sound and well-devised methodology for planning for the future hospice inpatient bed needs of the State as a whole. However, as is often the case with statewide methodologies, there are counties and providers that exist as outliers. In these counties, the standard methodology does not accurately determine need. JMH is aware of a petition filed by Southeastern Regional Medical Center to change the statewide hospice inpatient bed need methodology in the *2008 State Medical Facilities Plan*. That petition specifically addressed counties with substantially higher than average hospice use rates (total hospice days of care per 1,000 population). While the Long-Term and Behavioral Health Committee did not recommend approval of the petition as filed, it did recognize the validity of the health planning concerns raised in the Southeastern petition and as such, recommended that the hospice inpatient bed need determination be adjusted to zero in Robeson County as well as two other counties, each with extremely high hospice use rates and previously approved hospice inpatient beds pending development. The Committee also recommended the assembly of a task force to be comprised of The Carolinas Center for Hospice and End of Life Care, The Association for Home and Hospice Care of North Carolina, and various hospice providers in the State, to determine flaws in the current methodology and recommend appropriate changes to the methodology to be included in the *2009 State Medical Facilities Plan*. The State Health Coordinating Council subsequently accepted the Committee's recommendations. While the situation in Johnston County is not as extreme as that in Robeson County, JMH does believe that certain hospice utilization statistics in Johnston County contribute to a somewhat overstated need in the *2008 State Medical Facilities Plan* methodology. JMH believes that a need for additional hospice inpatient beds does in fact exist in Johnston County; however, JMH believes that the actual need is for four (4) additional inpatient beds as opposed to the eight (8) that result from the standard methodology in the *2008 State Medical Facilities Plan*.

Johnston County Hospice Utilization Statistics

Relevant hospice statistics that JMH believes contribute to the overstated need in the *State Medical Facilities Plan* include the following:

1. **The Johnston County hospice use rate (total hospice days of care per 1,000 population) is 24 percent higher than the North Carolina average** based on 2006 hospice utilization data reported in the Proposed *2008 State Medical Facilities Plan*.

Area	*2006 Hospice Days of Care*	*2006 Population*	*2006 Days of Care per 1,000 Population*
Johnston County	52,861	151,589	350.25
North Carolina	2,462,776	8,774,984	281.70
Johnston County Difference from North Carolina	--	--	24.3%

Source: Proposed *2008 State Medical Facilities Plan*

The number of hospice patient days is somewhat suspect given the number of hospice deaths in Johnston County. In contrast to the statistics presented above, the number of hospice deaths per 1,000 population in Johnston County is even less than the North Carolina average as shown below.

Area	*2006 Hospice Deaths*	*2006 Population*	*2006 Hospice Deaths per 1,000 Population*
Johnston County	285	151,589	1.9
North Carolina	22,653	8,774,984	2.6
Johnston County Difference from North Carolina	--	--	-27.2%

2. As a result of the high number of hospice patient days, **total hospice days of care per death in Johnston County are 71 percent higher than the North Carolina average** based on 2006 hospice utilization data reported in the Proposed *2008 State Medical Facilities Plan*.

Area	*2006 Hospice Days of Care*	*2006 Hospice Deaths*	*2006 Days of Care per Hospice Death*
Johnston County	52,861	285	185.5
North Carolina	2,462,776	22,653	108.7
Johnston County Difference from North Carolina	--	--	70.6%

Source: Proposed *2008 State Medical Facilities Plan*

3. JMH believes that one primary source of the disproportionately high number of hospice patient days as compared with the number of hospice deaths reported in Johnston County is likely related to the higher than average number of non-death hospice patient discharges. On average in North Carolina, approximately 19 percent of hospice patients were discharged from hospice care in 2006; the remaining 81 percent died while under hospice care. Under typical circumstances, hospice discharges rarely occur because of the nature of the service; patients are occasionally discharged because their physician believes they no longer meet the certification requirements of a limited life expectancy. **Non-death discharges as a percentage of**

total hospice admissions in Johnston County are 83 percent higher than the North Carolina average per 2006 hospice utilization data reported on 2007 Data Supplements to the Hospice License Renewal Application.

Area	*2006 Non-Death Discharges*	*2006 Hospice Admissions*	*2006 Days Non-Death Discharges per Hospice Admission*
Johnston County	139	404	34.4%
North Carolina	5,340	28,383	18.8%
Johnston County Difference from North Carolina	--	--	83.0%

Source: Data Supplements to 2007 Hospice License Renewal Application

The days of care associated with discharged patients are counted in the total hospice days of care and thus included in the need methodology for hospice inpatient beds. However, as these patients do not remain under hospice care, these patients are not included in hospice deaths and it is highly unlikely that they would require hospice inpatient care. Patients who are discharged from hospice are likely appropriate for death in the home rather than an inpatient setting. Therefore, the need methodology for hospice inpatient beds in the *State Medical Facilities Plan* is overstated by the inclusion of patient days associated with these discharged patients.

In counties where the rates of hospice discharge are more in line with the State average and hospice patients are discharged infrequently, the impact of these patient days in the methodology is minimal. However, in Johnston County, the impact of these patient days may result in an overstated need being generated for inpatient hospice beds that the discharged hospice patients will not utilize.

4. JMH believes that another primary source of the disproportionately high number of patient days is related to the higher than average number of nursing home days as a percentage of total hospice days of care in Johnston County. Specifically, **nursing home days as a percentage of total hospice days of care were 38 percent higher than the North Carolina average** in 2005 per The Carolinas Center for Hospice and End of Life Care's most recent compiled data available. According to the same data, **Johnston County ranks 12th among all North Carolina counties with regard to nursing home days as a percentage of total hospice days of care.**

Area	*2005 Nursing Facility Days of Care*	*2005 Total Hospice Days of Care*	*2005 Nursing Facility Days % of Total Days of Care*
Johnston County	12,687	40,558	31.3%
North Carolina	456,828	2,007,422	22.7%
Johnston County Difference from North Carolina	--	--	37.9%

Source: The Carolinas Center for Hospice and End of Life Care

Similar to non-death discharges, the days of care associated with nursing facility patients are counted in the total hospice days of care and thus included in the need methodology for hospice inpatient beds. However, only patients already under the hospice plan of care who are admitted to a nursing facility for inpatient care in the absence of a dedicated hospice facility would be appropriate for admission to a hospice facility if one existed. On the contrary, patients who are already residents of nursing facilities and subsequently seek hospice services prior to death, would be unlikely to move their residence from the nursing facility to a hospice facility even if one existed. Such patients would more likely continue to receive hospice services in the nursing facility setting to the point of death. Therefore, such patients would not be appropriate for admission to a hospice facility, and as a result, the need methodology for hospice inpatient beds in the *State Medical Facilities Plan* is overstated by the inclusion of patient days associated with these patients.

In counties where the rates of nursing facility utilization are more in line with the State average, the impact of these patient days in the methodology is minimal. However, in Johnston County, the impact of these patient days may result in an overstated need being generated for inpatient hospice beds that the nursing facility patients will not utilize.

Requested Change

JMH believes that a need for additional hospice inpatient beds does exist in Johnston County; however, JMH believes that the actual need is for four (4) additional inpatient beds rather than eight (8). Therefore, JMH requests an adjusted need determination for four (4) hospice inpatient beds for Johnston County in the *2008 State Medical Facilities Plan*. The following analyses support the reasonableness of this requested change.

If the Johnston County hospice use rate (350.25 days of care per 1,000 population) were lowered to the North Carolina average use rate (281.70 days of care per 1,000 population) and the standard *State Medical Facilities Plan* methodology applied, the following need for hospice inpatient beds in Johnston County would result.

County	*2006 Hospice Days of Care per 1,000 Population*	*2011 Projected Population**	*2011 Estimated Days of Care^*	*Estimated Inpatient Days#*	*Projected Total Beds Required***
Johnston	281.70	174,692	49,211	3,937	13

*Per the Proposed *2008 State Medical Facilities Plan*

^2006 Hospice Days of Care per 1,000 Population x (Projected Population/ 1,000)

#Estimated Days of Care x 8%

**Estimated Inpatient Days / 365 days / 85% occupancy

Based on the above adjustment and accounting for the eight (8) hospice inpatient beds that JMH has been previously approved to develop, Johnston County would show a deficit five (5) hospice inpatient beds as opposed to eight (8).

An alternative analysis involves adjusting Johnston County's 2006 hospice days of care to exclude a portion of the county's 2006 nursing facility days. To account for the fact that some nursing facility days of care are likely provided to existing hospice patients who are admitted to a nursing facility for inpatient care in the absence of a dedicated hospice facility (and who, therefore, would be appropriate for admission to a hospice facility), JMH has adjusted 2006 Johnston County hospice days of care to exclude 75 percent of the days of care provided in nursing facilities. Applying the standard hospice inpatient bed need methodology to this adjusted number of 2006 hospice days of care results in the following number of hospice inpatient beds needed in Johnston County.

County	*2006 Adjusted Hospice Days of Care**	*2006 Population*	*2006 Hospice Days of Care per 1,000 Population*	*2011 Projected Population*	*2011 Estimated Days of Care*	*Estimated Inpatient Days*	*Projected Total Beds Required*
Johnston	40,159	151,031	265.9	174,692	46,450	3,716	12

*52,898 total days of care - (16,986 x 75% = 12,739 nursing facility days) = 40,159 days of care

This analysis results in an even more conservative estimate of the number of hospice inpatient beds needed in Johnston County. Specifically, this analysis results in a total bed need of 12, which equates to a need for four (4) additional beds after accounting for the eight (8) that JMH currently has under development. Note that this adjustment to hospice days of care results in a 2006 hospice use rate in Johnston County of 265.9 days of care per 1,000 population, which is within 5 percent of the North Carolina average, further supporting the reasonableness of this analysis.

Summary and Implications if the Petition is Not Approved

A need for additional hospice inpatient beds clearly exists in Johnston County. However, JMH believes that the need identified in the *2008 State Medical Facilities Plan* is overstated for the reasons presented in this petition. A need determination for hospice inpatient beds that is overstated and statistically unsupported ultimately will result in duplication of services as well as the development of hospice inpatient beds that may not be financially feasible due to an inflated indication of demand. Given the lack of historical hospice facility utilization until JMH's previously approved inpatient beds become operational, and given the commitment of the State Health Coordinating Council to assemble a task force to determine the flaws in the current hospice inpatient bed need methodology for recommended changes to take effect in the *2009 State Medical Facilities Plan*, JMH believes the most prudent course of action at this time is to adjust the need determination for hospice inpatient beds in Johnston County to four (4) beds based on the more conservative of the two analyses presented above.

JMH appreciates your careful consideration of this petition. Please let us know if we can assist the Council, its committees, and the staff during the process.

Thank you very much.

Petition Inpatient Hospice – 6
Received Regarding Proposed 2008 State Medical Facilities Plan

Attached are:

1. Petition from Angel Hospice and Palliative Care.

2. Written comments received.

State Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

July 30th, 2007

Dear Council:

Enclosed is the Petition to the Health Coordinating Council to Adjust the Hospice Inpatient Need Methodology for Angel Hospice and Palliative Care in the 2008 State Medical Facilities Plan. Angel Hospice is located in Macon County, NC.

Contact persons.

Don Sandoval, CEO 828-524-8111 e-mail dsandoval@angelmed.org
Angel Medical Center
Riverview Street
PO Box 1209
Franklin NC 28744

Michele Alderson, President 828-524-6375 e-mail micheleralderson@yahoo.com
Angel Hospice Foundation hospicehousefoundation@yahoo
PO Box 815
Franklin, NC 28734

Thank you in advance for your serious consideration of our Petition.

PETITION FOR AN ADJUSTED NEED DETERMINATION FOR HOSPICE INPATIENT BEDS FOR MACON COUNTY

Petitioner:

Angel Hospice and Palliative Care
170 Church Street
Franklin, NC 28734

Requested Change:

Angel Hospice and Palliative Care (AHPC) seeks to provide comprehensive hospice care for terminally ill patients in Macon and Swain counties. By this petition, AHPC requests that the State Health Coordinating Council adjust the need determination reflected in the 2008 State Medical Facilities Plan for Hospice Inpatient Bed Need to identify the need for six hospice inpatient beds in Macon County. AHPC further requests that the Council consider their proposal to build a freestanding hospice facility with six hospice inpatient beds and four hospice residential beds.

About the Petitioner

Angel Hospice and Palliative Care is a hospital based Home Care Agency and is a department of Angel Medical Center. AHPC is Medicare and Medicaid Certified and is Joint Commission Accredited. AHPC is also a Member of the North Carolina Association of Home Care, the National Hospice Organization, and the Hospice of the Carolinas.

Justification For An Adjustment of Need for Inpatient Hospice Beds in Macon County

Need for Access to Inpatient Hospice Beds in Macon County
Based on the current need methodology, the 2007 SMFP shows there is a projected need determination for four hospice inpatient beds for Macon County but no need for an inpatient hospice facility. However there are a number of reasons that justify an adjustment to six inpatient beds to provide for a freestanding hospice facility in our area:

- Patients receiving inpatient services at AMC who would meet the requirements for placement in a hospice inpatient facility upon discharge are seldom offered that option due to limited or no access to this health service. Mountain Area Hospice, our closest hospice inpatient facility, is located 75 miles or more from the majority of hospice patients served in Macon County. This same facility reports occupancy of 90.8% in the 2007 SMFP. Macon County patients in need of hospice inpatient services are usually denied access to this option and must settle for less than optimal placement due to the long distance patients and families must travel and the lack of available capacity.

- Macon and surrounding counties have seen a huge increase in our retiree population further increasing the need for an inpatient hospice facility. According to the NC State Data Center, US Census data for 2000 indicates that 22.4 percent of the population of Macon County is age 65 or older compared to only 12.0 percent of the population in North Carolina aged 65 or older. And while North Carolina saw an increase in population between 1990 and 2000 of 21.4 percent, Macon County's growth rate was 26.8 percent.

- In addition to Macon County, Angel Hospice also serves patients in Swain, Graham and Clay counties and the Cherokee Indian Reservation. While there is no available data for the Cherokee Indian Reservation, Graham County shows a projected inpatient bed deficit of zero (0) and Cherokee, Clay, Jackson and Swain County each show a projected deficit of one hospice inpatient bed (Table 1). The total projected need for the six western counties is 8 inpatient beds. The 2007 SMFP totals show that 28.64% of deaths in Macon County were served by hospice. The same figures for other counties served by AHPC are: Swain 19.67%, Graham 6.06 %, and Clay 13.16% and figures for nearby counties show the rates for Jackson at 31.55% and Cherokee at 15.06%. It has been shown that the availability of a hospice inpatient facility increases the number of patients who choose this option for end-of-life care.

TABLE 1

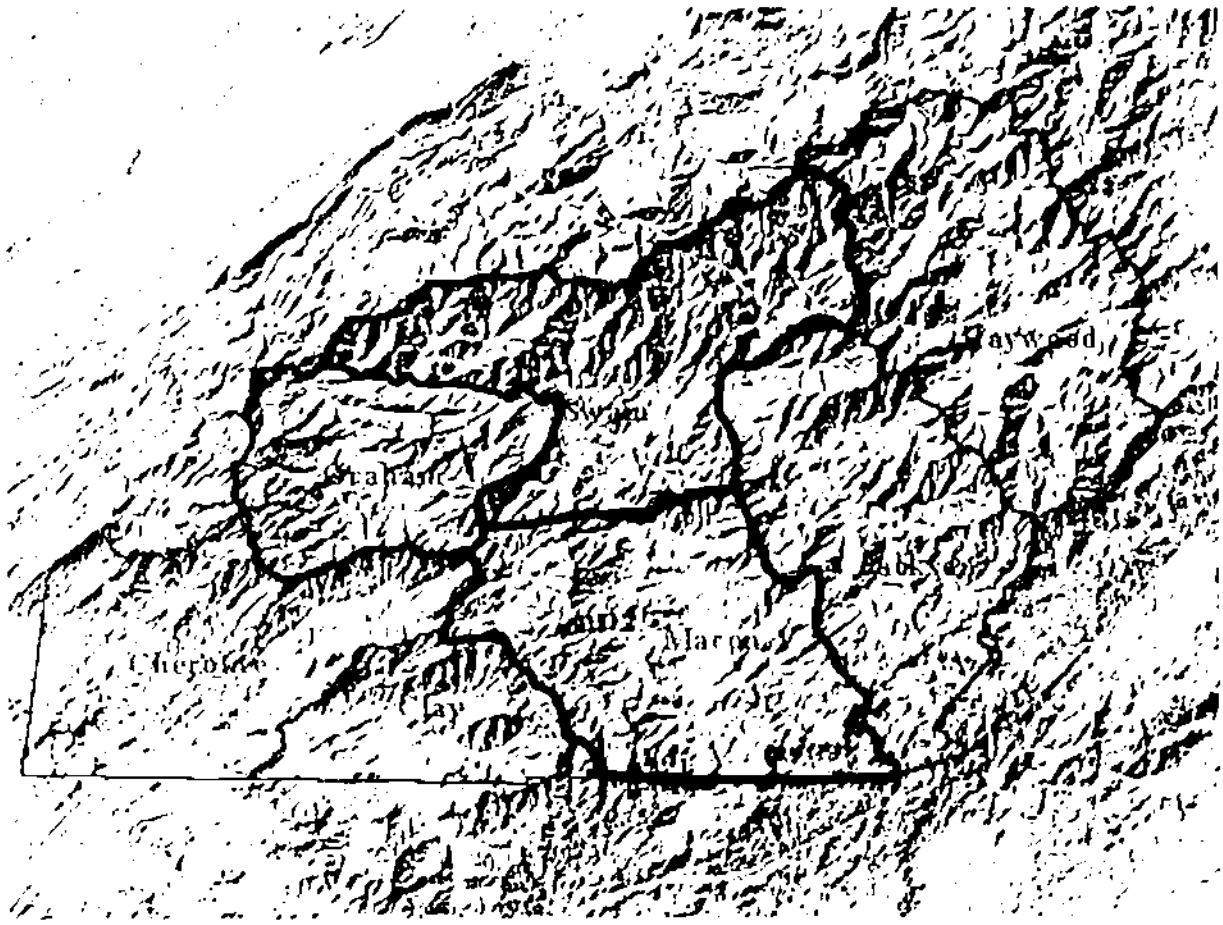
County	Macon	Jackson	Swain	Clay	Cherokee	Graham
Total Days of Care	9,368	5,219	3,362	3,285	4,840	513
2005 Population (Excluding Military)	32,540	35,748	13,584	9,859	26,173	8,120
Hospice Days of Care per 1000 Pop.	287.89	145.99	247.50	333.20	184.92	63.18
2010 Projected Population	35,512	37,754	14,308	10,732	27,996	8,357
Estimated Days of Care	10,224	5,512	3,541	3,576	5,177	528
Estimated Inpatient Days	818	441	283	286	414	42
Projected Inpatient Bed Deficit	4	1	1	1	1	0

Source: Table 13C: Year 2010 Hospice Inpatient Bed Need Projections for the 2007 Plan

- An inpatient facility will help family members when care needs go beyond the capabilities of the family caregiver(s). Even with the support of home health or home hospice care, family members frequently report that they cannot cope with the special demands of the situation. In 2007 there were many AHPC patients who requested or needed inpatient care but none was available. Hospice inpatient beds are sorely needed in Macon County to assure all patients, especially the underserved patients who are most vulnerable to limited resources and abilities, have access to this essential end-of-life health service.

- Macon County covers 517 square miles of mountainous terrain and our geography is an important factor to consider in determining the need for an inpatient facility. Travel times in the mountains are longer and more difficult than in other parts of the state, especially for elderly patients and caregivers. There are no hospice inpatient facilities in

the six westernmost counties of NC, an area of 2047 square miles with a population of over 125,000. According to the Inventory of Hospice Residential Beds in the SMFP there are no hospice residential beds in these counties. Macon County is centrally located to the multi county service area of AHPC. (Map 1)



MAP 1 Macon County is centrally located within the AHPC service area.

Mileage from:

Franklin (Macon County) to Asheville	75 miles
Bryson City (Swain County) to Franklin	31 miles
Robbinsville (Graham County) to Franklin	50 miles
Hayesville (Clay County) to Franklin	37 miles
Cherokee Reservation (Jackson County) to Franklin	29 miles

- As described in the 2007 SMFP, the State's current need determination projections are based on a six-bed deficit threshold for single counties to trigger a need for inpatient hospice beds. Angel Hospice petitions for an adjusted need determination for an inpatient hospice facility in Macon County based on the combined contiguous county deficits of 4 hospice inpatient beds in Macon County and one hospice inpatient bed each in Clay, Cherokee, Jackson and Swain counties.

Approval of this petition will allow Angel Hospice the opportunity to submit a Certificate of Need application to develop a freestanding inpatient hospice facility. Should the adjusted need determination be granted, Angel Hospice would like to include six residential beds with the four inpatient beds to create comprehensive hospice services in Macon County that will serve residents in Macon and Swain counties as well as residents of other contiguous counties including Jackson, Clay and Graham counties, and Rabun County in Georgia.

Although the projected need for inpatient hospice beds in the 2007 SMFP shows a zero deficit for Graham County, and a deficit of only eight inpatient beds by combining the needs of Macon (4), Jackson, Clay, Cherokee and Swain counties (1 each), the six far western counties nevertheless have a need for this facility. With such low projected needs and a six-bed deficit threshold, the feasibility of providing an inpatient hospice facility in the far west appears unlikely in the near future. However, the lengthy process involved in building such a facility speaks to the need to start such a process. A growing population, a large number of retirees moving to this area, strong community support, an increasing use of hospice services, a lack of other facilities in the area, and our special geographic considerations are all factors we ask the Council to consider in this petition. A comprehensive inpatient hospice facility in Macon County could serve the immediate needs of the far western region.

Need for Cost Effective Approaches to Health Services
Patients admitted to and cared for in a hospice inpatient facility incur significantly less cost to Medicare than those admitted to acute care centers. Additionally, some hospice patients require frequent readmissions for acute care services. Angel Medical Center is focused on providing an environment directed to acute, life-saving interventions versus the palliative and supportive care of a hospice patient in need of temporary remedies. Currently, readmissions of hospice patients must be managed in an environment that is not only more costly but is also not the most appropriate environment for most hospice patients. Acute care services provided in a hospice inpatient bed have been proven to be more cost-effective and appropriate than acute care services provided to hospice patients in other settings.

Need for Quality Health Services
Quality healthcare services have been defined as the right care, at the right time, in the right place for the right patient. Acute care services provided in hospitals are not generally geared to the unique needs of hospice patients and their families. Macon County needs an inpatient hospice facility to assure the continuum of quality hospice services are available for those patients that need and select this option of end-of-life healthcare.

Community support is also vital to assuring a quality healthcare service is developed and sustained in a service area. The community support for a hospice inpatient facility in Macon County has been overwhelming as the letters included with this petition demonstrate. The non-profit Angel Hospice Foundation has also been created with a mission to provide funding and ongoing support to a hospice inpatient facility in Macon County.

Alternatives to the Proposed Adjustment in Need Determination

One alternative to the development of a hospice inpatient facility in Macon County would be to continue to use AMC acute care beds and referrals to area nursing facilities. AMC beds are designed and needed for high acuity patients. Continuing to use AMC inpatient beds for hospice inpatient services is inappropriate and only reinforces the gap in access to quality, cost-effective hospice care in Macon County.

Another alternative would be the development of enhanced palliative care services in AMC. Angel Hospice Foundation and AMC have developed a hospice respite bed at AMC, however certain issues such as bed availability, access to a full-range of quality options, and cost-effectiveness still remain. These alternatives do not fully address the need for access to hospice inpatient beds and the development of more cost-effective approaches to end-of-life care. Maintaining the status quo or building on existing programs cannot fully support the community's need or commitment to a hospice inpatient facility.

Evidence That Need Adjustment Would Not Duplicate Health Resources

An adjustment to the hospice inpatient need determination for Macon County would not present any unnecessary duplication of health resources. The 2007 SMFP reports that the hospice inpatient facility in Buncombe County experiences a 90.8% occupancy rate and that this facility reported that none of their patient days were from Macon County. Macon County has a significant gap in access to hospice inpatient beds that is not being met by any other facility.

Conclusion

In summary, the lack of hospice inpatient beds to serve the number of patients who would benefit from such services can be addressed by adjusting the need determination for hospice inpatient beds in Macon and Swain counties. AHPC respectfully requests that an adjustment be made to the need determination in the 2008 SMFP to identify the need for an inpatient hospice facility with six Hospice Inpatient beds in Macon County.

This the 29th day of July 2007.

Director
Angel Hospice and Palliative Care
Angel Home Health

Angel Hospice and Palliative Care is a distinct service line operated and provided by Angel Medical Center. The Medical Center is strongly committed to the provision of Hospice Services to citizens of Macon County. While we are not prepared to be solely responsible for all operational costs of a freestanding facility at this time, we are actively negotiating with the Angel Hospice Foundation to seek ways to fund this new service. Please contact me with any questions.

Donald D. Sandoval, FACHE, CEO
Angel Medical Center

July 25, 2007

State Health Coordinating Council
Long Term & Behavioral Health Committee
Dr. T. J. Pulliam, Chair
2714 Mail Service Center
Raleigh, North Carolina 27699

Gentlemen:

This letter is written in support of the need for a Hospice Inpatient Facility to be located in Franklin, North Carolina. Currently the nearest inpatient facility is in Asheville, North Carolina. There are many who live west of Asheville that would be more conveniently assisted if a facility were here. Macon County is a good location readily accessible to the surrounding counties. A Hospice Inpatient Facility would be of great benefit to those terminally ill as well as their families.

My family has been the recipient of the wonderful care and compassion given by the Hospice people. We know from experience the help provided was of value beyond measure. Fortunately, we were able to keep our Father at home until the end. Other families may not be able to do the same or may need short term assistance.

Please give great consideration to this worthy need for an inpatient facility to be located in Franklin.

Sincerely,

Margaret E. Snyder

Margaret E. Snyder

July 20, 2007

State Health Coordinating Council
Long Term and Behavioral Health Committee
Dr. T.J. Pulliam, Chair
2714 Mail Service Center
Raleigh, NC 27699

Dear Dr. Pulliam:

I wish to express my interest in an inpatient hospice facility for Macon County, North Carolina. We are so fortunate to have the home services now provided by Angel Hospice in our county, but there is a great need for people without family members who can provide 24/7 care in their last days.

My family's experience with Angel Hospice was a blessed time, my Father was able to remain at home and have all the love and care he needed in his final days and at the same time we as family members received wonderful physical and spiritual help. I cannot say enough good things about hospice.

I would ask you to please consider this need, since there is no inpatient hospice facility west of Asheville, North Carolina.

Sincerely,

Elizabeth C Hall

Elizabeth C. Hall

July 25, 2007

State Health Coordinating Council
Long Term and Behavioral Health Committee
Dr. T.J. Pulliam, Chair
2714 Mail Service Center Raleigh, NC 27699

Dear Mr. Pulliam:

I am writing this letter in support of the drive to establish a Hospice House in Franklin. I believe this would be very beneficial not only to Macon County, but also the entire western region of the State south of Asheville. I am sure there are caregivers who face a real dilemma when work or other demands take them out of town overnight. There are also times when it is impossible to care for a loved one without the help Hospice provides. I experienced this when my mother, whom I care for, and I both had a virus. From my experience with the great work Hospice does, I am sure any patient would receive the very best of care

I hope you will sincerely consider the establishment of a Hospice House in Franklin.

Thank you.

Respectively,

Revena Shuler

Revena Shuler

ANGEL
HOME HEALTH & HOSPICE
an affiliate of Mission St Joseph's Health System

170 Church St
Franklin, NC 28734
(828) 369-4206
Fax (828) 369-4400

PO Box 389
Bryson City, NC 28713
(828) 488-3877
1-800-721-4446
Fax (828) 488-9288

PO Box 1519
Robbinsville, NC 28771
(828) 479-2110
1-800-328-4691
Fax (828) 479-3838

July 25, 2007

Dr. T. J. Pulliam, Chair
Long-Term and Behavioral Health Committee
State Health Coordinating Council
2714 Mail Service Center
Raleigh, NC 27699-2714

Dear Dr. Pulliam,

The Angel Hospice Foundation hopes to build an inpatient hospice house in our community to serve both Macon County and surrounding counties, as well. There is no such facility in our state west of Asheville.

Angel Hospice strives to provide the highest level of care for our patients and their family members. Ideally we assist families to care for their loved ones in the relative comfort and familiarity of their own homes. On occasion, however, this is impossible. Sometimes the patient's spouse is too infirm to provide adequate care. Sometimes the caregiver must go away for a short period. Sometimes the multiple needs of the patient overwhelm the caregiver

For the past fourteen years I have been involved in hospice work in some capacity. I have observed and have experienced personally just how difficult caring for a dying loved one can be. No inpatient hospice facility was available when my mother was terminally ill, suffering from dementia and a series of strokes. Hospitals, nursing homes, and a patient's own homes all can help to meet the needs of someone in hospice. Unfortunately, the absence of an inpatient facility is like offering a bed missing one of its four legs.

I deeply appreciate your consideration of this important need. Many people stand to benefit from a hospice house here in Macon County, most of all those folks who are experiencing the greatest needs with the least support

With thanks,

Victor A. Greene

Victor A. Greene, D. Min
Chaplain, Angel Hospice

July 25 2007
100 old mill rd
Franklin, NC 28734

Dr. T.J. Pulliam, Chair
State Health Coordinating Council
Long Term & Behavioral Health Committee
2714 Mail Service Center
Raleigh, NC 27699

Thes letter is To support the Need for a INPatient Hospice House to Serve All Counties west of asheville, NC. To Meet the Needs of Hospice patients & their families with terminal illness.

Thank you
Madge B Howard

July 24, 2007

State Health Coordinating Council
Long Term & Behavioral Health Committee
Mr. T. J. Pulliam, Chair
2714 Mail Service Center
Raleigh, NC 27699

Dear Mr. Pulliam,

Please be advised that I firmly support the Angel Hospice Foundation in their efforts to establish a hospice inpatient facility in Macon County. I have experienced the care and compassion given to my family member by the Angel Hospice staff. At the end of my aunt's life, she was placed in a nursing home since we could not provide the care she needed at home. She wanted her hospice nurses to be there but unfortunately hospice cannot procure care in a nursing home for thirty days. My aunt passed away before the 30 days. She was frightened in the nursing home with no familiar caregivers. If we had an inpatient hospice facility she would have been with the people she trusted her care with for the last 3 months of her life.

Sincerely,
Debra Joyce & Barbara Hasson
1113 Cowetta Lake Road
Otto NC 28763

ANGEL
HOME HEALTH & HOSPICE
an affiliate of Mission St Joseph's

170 Church St
Franklin, NC 28734
(828) 369-4206
Fax (828) 369-4400

PO Box 389
Bryson City, NC 28713
(828) 488-3877
1-800-721-4446
Fax (828) 488-9288

PO Box 1519
Robbinsville, NC 28771
(828) 479-2110
1-800-328-3691
Fax (828) 479-3845

July 25, 2007

State Health Coordinating Council
Long Term & Behavioral Health Committee
Dr. T.J. Pulliam, Chair
2714 Mail Service Center
Raleigh, NC 27699

Dear Dr. Pulliam,

I am writing this letter in full support of building a Hospice House in Macon County. I have the privilege of working for Angel Hospice in Franklin, NC. Our goal is to offer the highest level of quality care to our patients. We are presently serving the needs of our terminally ill patients in their homes. Sometimes a patient will need more care than the family members, or hospice staff, can provide in the home. There are also residents in the community who have no caregiver, and presently have to go to a hospital, or care center for end of life care. A Hospice House will provide a home-like setting for patients to receive comfort care for themselves, as well as much needed emotional support for their families

At the present time there is no Hospice House west of Asheville, NC.
A Hospice House in Macon County would prove to be a huge asset for not only this county, but the surrounding counties, as well. Please help us to provide this much needed inpatient facility for those in need of quality end of life care in Macon County

Thank You for your support of this very important project!

Sincerely,
Bette Balmer

Bette Balmer
Bereavement & Volunteer Coordinator
Angel Hospice

July 18, 2007

State Health Coordinating Council
Long Term & Behavioral Health Committee
Dr. T. J. Pulliam, Chair
2714 Mail Service Center
Raleigh, NC 27699

Dear Dr. Pulliam:

I am writing this letter in support of Angel Hospice Foundation's petition to adjust the Hospice Inpatient Need Methodology in the 2008 State Medical Facilities Plan.

I have lived in Franklin, NC since the fall of 2001. From September 2005 to April 2006 I was employed by Angel Medical Center, Angel Hospice and Palliative Care as their Volunteer Coordinator. I left that position after having been diagnosed with Prostate Cancer. During the time that I worked for Angel Hospice I learned how important hospice care is to this community and the great service they perform for its citizens. All of our patients were attended to in their homes. But, we often had situations where a patient needed hospice care but could not qualify for it because they did not have a full time caregiver available. As you may know, this area of Western North Carolina has a large elderly population many of whom, like myself, live alone and do not have family living nearby and also do not have the resources to hire care givers or move to a skilled nursing facility. By having a hospice inpatient facility people in this situation would have a chance at receiving hospice care. It would also provide a respite for caregivers of homebound patients.

I hope that your committee will give the Angel Hospice Foundation, Inc. petition your favorable consideration.

Sincerely,

Michael James Flynn
131 Franklin Plaza, #210
Franklin, NC 28734

WestCare Home Health and Hospice
212 Sylva Plaza
Sylva, NC 28779

July 26, 2007

Dr. T.J. Pulliam
State Health and Coordinating Council
Long Term & Behavioral Health Committee
Dr. T.J. Pulliam, Chair
2714 Mail Service Center
Raleigh, NC 27699

Dear Dr. Pulliam,

SUBJECT: LETTER OF SUPPORT FOR HOSPICE FACILITY IN MACON COUNTY

I am writing this letter in support of Angel hospice Foundations petition to build a Hospice Inpatient facility in Macon County. I believe that this project will enhance the scope of services by providing both residential and inpatient hospice care to more effectively medically manage patients in a home like environment. It has been my experience that freestanding Hospice facilities are overwhelmingly successful. The hospice principles and practices are their primary goal. They have much better control over programs, services, quality and utilization and can provide theses services in a homelike setting.

While there is an inpatient facility in Asheville, it is located more than 60 miles away, over mountain areas. The availability of beds is first given to residents of Buncombe County. Admission to this facility has been refused because patients, caregivers and family feel it is too far to travel. The facility has also had a waiting list when we have inquired about rooms. Many patients who would benefit from care would be separated from their family and friends at a time when they need to be close. By going out of the area they would also leave their primary physician, church support and neighbors.

Western North Carolina is a rapidly growing area. Many of the patients who currently need hospice inpatient care for symptom management are admitted to an acute care hospital. The inpatient beds are more expensive. The hospital often requires labs and other test and does not specialize in the provision of interdisciplinary and holistic end of life care.

Thank You for your consideration in this matter. Hopefully the decision will be a positive one that will have a great impact on the care of the terminally ill patients in Western Carolina. We the If you should have any further questions please feel free to contact me at 828-586-7410.

Sincerely,

Barbara Klein, RN

Director
WestCare Home Health and Hospice

July 23, 2007

State Health Coordinating Council
Long Term & Behavioral Health Committee
Dr. T.J. Pulliam, Chair
2714 Mail Service Center
Raleigh, NC 27699

Dear Dr. Pulliam,

I have been a resident of Macon County since 1980, and have seen a lot of growth and change here. Almost 4 years ago, my sister became terminal and we enlisted the aid of the local Hospice organization to make her final days more comfortable and pleasant. She was a patient at one of our local Nursing/Rest homes. It was very hard on all the family. After she passed I became a Hospice Volunteer due to what I had learned of Hospice. My regret is that we do not have a Hospice House here in Macon County. There is such a need for a house that I urge you to assist us in procuring one. There is not a facility west of Asheville. All of the counties surrounding Macon would benefit greatly.

My entire family supports the Hospice theory, and seek your support.

Thank you,

Sallee Coss

Sallee Coss
220 Cliff Dalrymple Road
Franklin, NC 28734

249 Bates Branch Rd.
Franklin, NC 28734

July 21, 2007

Dr. T. J Pulliam, Chairman
State Health Coordinating Council
2714 Mail Service Center
Raleigh, NC 27699

Dear Dr Pulliam,

Having had both my mother and an aunt in Hospice Houses during their final stage of life, I realize how valuable such a facility is to those whose families can not care for them at those times.

Here in western N.C. there is a strong family ethic -- folks care for their own. There are also many "retirees" living here who are far from their families & when illness strikes they are often on their own. For either group, the "natives" and the "transplants" the wish to care for family or be cared for by family in one's own home may not always be possible. It is for this reason that I strongly feel there is a need here for a Hospice House. Please help us make it happen!

Sincerely,
Janet Hill

Michael and Nancy D. Falkenstein
119 Pinecrest Drive
Franklin, NC 28734

July 21, 2007

State Health Coordinating Council
Long Term & Behavioral Health Committee
Dr. T.J. Pulliam, Chair
2714 Mail Service Center
Raleigh, NC 27699

Gentlemen:

This letter is in support of the Angel Hospice Foundation's mission to obtain funds for the construction and endowment of an Inpatient Facility for our community and to support Hospice.

Personally, we have had a sister die in a nursing home with Hospice Care which for all was a horrific experience. Recently, we had Hospice Care for my mother-in-law in an Assisted Living Facility in Sarasota, Florida, where we saw first hand the difference. We know many hospice volunteers and understand and appreciate what Hospice does.

The need for an inpatient facility in Franklin to provide not only respite care, but care for those who do not have family close-by who can help, is a real one, and the need will become greater as time goes on. We hope to see in Franklin in the near future an Inpatient Hospice Facility that will serve not only Macon County residents but those west of Asheville in neighboring counties.

We trust you will support this project and the efforts of Angel Hospice Foundation.

Sincerely,

Michael and Nancy D. Falkenstein

Dick and Molly Gray
79 Quail Ridge Road
Franklin, NC 28734
Phone: 828-342-9288
Email: dickandmolly@verizon.net

July 23, 2007

Dr. T. J. Pulliam, Chair
State Health Coordinating Council
Long Term and Behavioral Health Committee
2714 Mail Service Center
Raleigh, NC 27699

Dear Dr. Pulliam:

This letter is written in support of an inpatient facility for hospice care to be constructed in Franklin, NC. There are frequently hospice individuals whose care requires more than what family members and hospice staff can provide in the home. We desperately need an inpatient hospice facility to meet these needs.

At the present time, there is not a Hospice House west of Asheville. A Hospice House in Franklin can reach beyond our own Macon County to serve patients and their families in all counties from Asheville to Murphy.

Please seriously consider adjusting the hospice inpatient need methodology for Angel Hospice in Franklin in the 2008 State Medical Facilities Plan. We NEED a Hospice House and will greatly appreciate your assistance in paving the way toward the this goal of our Hospice Foundation.

Sincerely,

Dick and Molly Gray

1480 AM THE DOVE

WITH PRAISE FOR JESUS

July 20, 2007

State Health Coordinating Council
Long Term & Behavioral Health Committee
Dr. T. J. Pulliam, Chair
2714 Mail Service Center
Raleigh, NC 27699

Dear Dr. Pulliam,

I am writing this letter in full support of a "Hospice House" (Inpatient Facility) in Macon County.

As an American Cancer Society volunteer, I am keenly aware of the situation many families find themselves when a loved one is diagnosed with a terminal illness. In many cases, it takes them by surprise and is certainly something they neither expect, nor make plans for, as a family. A Hospice House would be a wonderful way to keep a caregiver close to their own extended family while being near their loved one.

As a Cancer Survivor, I know the uncertainties of a serious disease only make us want to be as close as possible to those we trust and love. A Hospice House would facilitate this need if, in fact, it became necessary for our families to place us there.

A Hospice House in Macon County is a much needed facility and, in my opinion, would be a God-send to our area.

Sincerely,

Brenda Wooten

Brenda Wooten
Community Events Coordinator
WPFJ Radio
Franklin, N. C.

185 Franklin Plaza
Franklin, NC 28734
828 369 5033

www.wpfj.com

WPFJ 1480 AM STEREO

Print Message

Close this window

From glen547@charter net
Date 2007/07/21 Sat AM 08 14 17 CDT
To warren schmidt@verizon net
Subject Letter

Dear Dr Pulliam,

I have been a practicing medical oncologist for over 30 years and hospice care has always been an integral part of terminal care for my patients. My initial practice was in New Haven, CT where the first Hospice House in the nation was built It was a huge success and provided a very much needed facility for patients to experience their last days in dignity and comfort with surrounding family

I now practice in Athens, GA and we have recently had a Hospice House built in our community I wholehearedly supported this venture both financially and spiritually It has provided a much needed refuge for patients, who for whatever reason, are unable to spend their remaining days at home

My wife and I have built a home in Highlands and for the last three years have spent as much time as possible in this lovely community It has come to my attention that Macon County and the surrounding counties are in need of a Hospice House The nearest facility is in Asheville, ninety minutes away, and this clearly is not a good option for families who want to spend quality time with their loved ones in their last days

I strongly urge you to approve a Hospice House for Macon Counbty - it truly will make a difference and enable patients with terminal illnesses to die with dignity surrounded by those who love them

Sincerely,

R Glen Wiggans, MD

Asheville PH
July 13, 2007

PUBLIC HEARING , STATE MEDICAL FACILITIES PLANNING BOARD 7/13/07
ASHEVILLE, NORTH CAROLINA

Petitioner:

Angel Hospice & Palliative Care
170 Church Street
Franklin, NC 28734

Comments by:

Michele Alderson
Hospice Volunteer
Angel Hospice & Palliative Care

Angel Hospice and Palliative Care (AHPC) seeks to provide a comprehensive hospice care for terminally ill patients in Macon, Swain and Graham counties. By this petition, AHPC requests that State Health Coordinating Council adjust the need determination reflected in the 2007 State Medical Facilities Plan for Hospice Inpatient Bed Need to identify the need for four hospice inpatient beds and four residential beds.

There a currently two hospices in Macon County; AHPC and Highlands Cashiers Hospice. Patients receiving inpatient services upon discharge who would meet the requirements for placement in a hospice inpatient facility are not offered this option. Nursing homes are their only option for both these hospices.

I joined AHPC five years ago as a patient volunteer. I feel very privileged to serve our patients and families. We have forty-five volunteers in our hospice. Our volunteers have formed a 5013c Foundation. Our Mission is to obtain funds and endow an inpatient/residential hospice facility in our community. Our board members are not only from Macon County. Adjoining Jackson County is represented on our board by West Cares' Hospice Medical Director, and a family physician . These two doctors see the need for a hospice residence and are passionate about seeing it come to fruition for their patients.

We have strong community support for our mission. Donations are already coming in, even though we have not begun our capital campaign.

The closet inpatient facility is in Asheville, which is 75 miles from our county. Our county is one of the fastest growing counties in western North Carolina. We have one of the largest retirement communities west of Asheville.

Hospice inpatient beds are sorely needed in Macon County to assure all patients, especially the underserved patients who are most vulnerable to limited resources and abilities, have access to this end - of - life health service.

Approval of this petition will allow AHPC the opportunity to submit a Certificate of Need application to develop a freestanding inpatient hospice facility.

We respectfully request that an adjustment be made to the need determination in the 2008 SMFP to identify the need for four Hospice Inpatient beds in Macon County.

Asheville PH
July 13, 2007

Name: Evelyn M. Byrnes

Address: 705 Highlands Cove Drive
Highlands, NC 28741

I am here as Hospice Volunteer for the Highlands Cashiers Hospital and as a member of the Angel Hospice Foundation Board of Directors to support the approval of their current petition to establish a Hospice House for Western North Carolina patients.

Asheville PH
July 13, 2007

Name: Evelyn M. Byrnes

Address: 705 Highlands Cove Drive
Highlands, NC 28741

I am here as Hospice Volunteer for the Highlands Cashiers Hospital and as a member of the Angel Hospice Foundation Board of Directors to support the approval of their current petition to establish a Hospice House for Western North Carolina patients.

Comment
Received Regarding Proposed 2008 State Medical Facilities Plan

Attached is comment received supporting petitions for inpatient hospice beds.

Asheville Public Hearing
July 13, 2007

I am Rita Burch, Hospice of Rutherford County. I am speaking to the need of Hospice. In the 2007 Plan it shows Rutherford County needing four (4) beds. We submitted our special need petition showing we needed six (6) more beds and thankfully that was approved. We will submit a Certificate of Need for that in September. So as far as the Proposed 2008 Plan I would like to speak on behalf of the hospices that are represented here today, that is Angel Hospice in Macon County, Hospice of Winston Salem in Forsyth County and Haywood Regional Hospice in Haywood County. Hospice services are growing so quickly so when that data come forth if you will take in consideration the current data because the hospice inpatient beds are saving lots for the communities, the hospitals are enjoying it and I just think the hospice growth shows the needs for these beds.

Petition: ESRD
Received Regarding Proposed 2008 State Medical Facilities Plan

Attached are:

1. Agency Report
2. Petition and Comments

AGENCY REPORT

ESRD Petition - Dialysis Services for Transylvania County

Petitioner

Transylvania County Department of Public Health
Steven E. Smith, Director
Community Services Building
98 East Morgan St.
Brevard, NC 28712

Request

The Petition requests an Adjusted Need Determination for a new dialysis facility to be located in Transylvania County.

Background Information

The current dialysis methodology assesses individual "County Need" for each of North Carolina's 100 counties on a semiannual basis. The methodology states, "if a county's...projected station deficit is ten or greater...the county station need determination is the same as the projected...station deficit." However, if "...the projected station deficit is less than ten...the county's...station need determination is zero." *(NOTE: This portion of the methodology also references utilization of existing facilities, but those references were excluded in this excerpt because Transylvania County does not have any existing dialysis facilities.)*

The threshold of ten stations is taken from a "Basic Principle" of the dialysis methodology, which states, "[n]ew facilities must have a projected need for at least 10 stations (or 32 patients at 3.2 patients per station) to be cost effective and to assure quality of care." This basic principle was intended to assure that new facilities would have a sufficient number of patients to establish quality services and to be financially viable.

Analysis/Implications

There are currently no End Stage Renal Dialysis Facilities located in Transylvania County and the July 2007 Semiannual Dialysis Report (SDR) projects a need for seven stations. Also, according to the July 2007 SDR there were 24 dialysis patients residing in Transylvania County as of 12.31.2006 and the Five Year Average Annual Change Rate for the Transylvania County dialysis population was +3.0%. Additionally, the Petitioner asserts that there are families in Transylvania County who would relocate a loved one receiving dialysis treatment to a local nursing home if there were a dialysis facility in Transylvania County.

Due to the region's mountainous terrain, dialysis patients residing in Transylvania County face unique challenges traveling to and from treatment. To attest to the travel difficulties encountered by Transylvania County dialysis patients, the Petitioner has provided letters of support from patients, family members and community leaders from Transylvania County including expressions of concern about traveling hazardous roads in

adverse weather and about long-commutes for medically-fragile patients. Given that most dialysis patients must have treatment three times a week, travel to and from treatment is a critical factor for dialysis patients. In the past, the State Health Coordinating Council has recognized the unique needs of dialysis patients residing in mountainous areas and has responded favorably to Adjusted Need Determination Petitions from the counties shown below:

- McDowell County – allowed development of a nine-station dialysis facility.
- Cherokee, Clay and Graham Counties – combined into one service area and allowed development of a ten-station dialysis facility.
- Avery, Mitchell, and Yancey Counties – combined into one service area and allowed development of a nine-stations dialysis facility.

Additionally, the Agency notes receipt of a letter from Fresenius Medical Care, an ESRD services provider, supportive of an Adjusted Need Determination for an eight-station facility in Transylvania County.

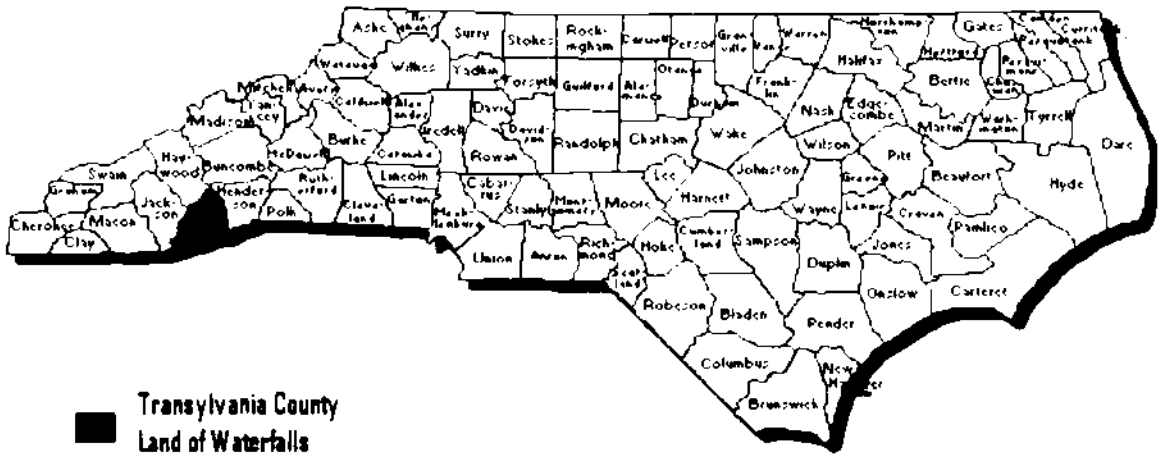
Agency Recommendation

Based on current Transylvania County data, anticipated growth in the number of dialysis patients, and support from Fresenius Medical Care, the Agency recommends approval of an Adjusted Need Determination for an eight-station dialysis facility to be located in Transylvania County.

Petition

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Method for Projecting New Dialysis Station Need
(End-Stage Renal Disease Dialysis Facilities)



July 13, 2007

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Submitted by: Transylvania County Department of Public Health on behalf of Transylvania County

Submitted on: July 13, 2007

Submitted at: Public Hearing – Proposed 2008 State Medical Facilities Plan
Mountain Area Health Education Center (MAHEC)
501 Biltmore Avenue
Second Floor – Classroom #1
Asheville, NC

Submitted to: Medical Facilities Planning Section
Division of Facility Services/NC Dept. of Health and Human Services

- Mr. Floyd Cogley
- Mr. Tom Elkins
- Ms. Victoria McClanahan

Long-Term and Behavioral Health Committee
NC State Health Coordinating Council

- Dr. Thomas J. Pulliam
- Mr. Jerry Parks
- Mr. Donald Beaver
- Mr. Ted Griffin
- Mr. Ken Hodges
- Ms. Frances Mauney
- Mr. Timothy Rogers

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Table of Contents

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Petitioner Contact Information

Steven E. Smith, Director – Transylvania County Department of Public Health
Community Services Building
98 East Morgan Street
Brevard, NC 28712

(828) 884-3135
Steve.smith@transylvaniacounty.org

Statement of the requested adjustment

Transylvania County finds the current need determination methodology (and its application) for end-stage renal disease dialysis facilities as outlined in Chapter 14 of the *Proposed 2008 State Medical Facilities Plan* to be inappropriate. The current methodology and its application to Transylvania County do not support the basic principles underlying the development of the *Proposed 2008 State Medical Facilities Plan* or the basic principles underlying the projection of need for additional dialysis stations (Chapter 14).

More importantly, the current process fails to adequately gauge the extent and degree of need experienced by current Transylvania County dialysis patients. We maintain that reasonable consideration of the extreme travel distances and travel time currently endured by Transylvania County dialysis patients in addition to other factors warrants an adjustment to the *Proposed 2008 State Medical Facilities Plan* to support establishment of a local dialysis facility in Transylvania County.

We are requesting the endorsement and approval of the North Carolina State Health Coordinating Council for this specific adjustment to the *Proposed 2008 State Medical Facilities Plan* so that Transylvania County can proceed with a Certificate of Need application to establish an end-stage renal disease dialysis facility in the immediate future.

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Reasons for the requested adjustment

Inappropriate/inadequate methodology & application

The current need determinations process for dialysis facilities is overly focused on jurisdictions (without a dialysis facility) achieving 32 dialysis patients (projected need) in order to warrant consideration for establishment of a local dialysis facility. We do understand the preference for that level of need and operation as it relates to cost effectiveness. While 10 stations (3.2 patients/station) operating at 80% utilization may be the minimum goal for dialysis facilities, this standard is clearly not being met for a significant percentage of existing facilities. The *July 2007 NC Semiannual Dialysis Report* stipulates that 48% of the certified facilities (71 of 149) are operating below this threshold.

Ten (10) existing dialysis facilities have a lower patients per station utilization rate than Transylvania County would have with its current projection of 12/31/2007 in-center patients (would yield a patients per station utilization rate of 2.16 if we had a dialysis facility today).

Requiring Transylvania County to achieve a projected need which exceeds the current utilization rate for 48% of the state's certified facilities is not equitable.

The second issue is that a regional context is not considered or applied to the current needs determination process for expansion of existing facilities in relation to decisions about establishment of new facilities.

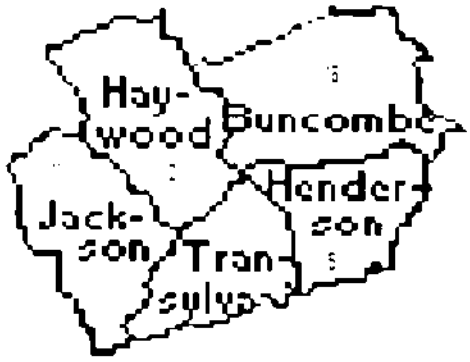
*Please reference the Regional Map on the next page.

It is evident that there are projected station surpluses in every county adjacent to Transylvania County (*July 2007 NC Semiannual Dialysis Report).* Some of these projected surpluses are extreme (Jackson County – 11 stations, Buncombe County – 18 stations). Henderson County shows a projected surplus of 5 stations and it is our understanding that they just expanded by 2 stations in January of this year. It is our contention that *a* regional zip code based analysis would demonstrate that a dialysis facility located in Transylvania County would dramatically improve access to our local dialysis patients and would better serve dialysis patients in southern Buncombe County and western Henderson County.

Denying Transylvania County the opportunity to establish a local dialysis facility while maintaining extreme station surpluses in adjacent counties is not equitable.

Regional Map of Transylvania County and surrounding counties

- Station surpluses as identified in July 2007 NC Semiannual Dialysis Report
  Total surplus: 36 stations



Facts

Transylvania County has the third highest projected 12/31/2007 In-Center Patients total (21.6) for all dialysis station planning areas without a dialysis facility in their jurisdiction.

Ten (10) existing dialysis facilities have a lower patients per station utilization rate than Transylvania County would have with its current projection of 12/31/2007 in-center patients (would yield a patients per station utilization rate of 2.16).

As of December 31, 2006, only 52% (78 of 149) of the certified facilities were operating at or above 80% utilization (3.2 patients per station or 32 patients for a minimum of 10 stations) – this means that 48% (71 of 149) of the certified facilities operating in NC are functioning below the level required of us to establish a new dialysis facility.

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Reasons for the requested adjustment

Inappropriate/inadequate methodology & application (continued)

The third and final issue is the lack of consideration related to local nursing homes. We have defined that nursing homes in Transylvania County decline multiple dialysis patients each year due to the tremendous transportation burden that would be assumed. The *Proposed 2008 State Medical Facilities Plan* fails to consider potential dialysis patient populations that could be established in local nursing homes if a local dialysis facility existed. If you consider the dialysis facility to be the "egg", the current plan takes a chicken-egg approach. Transylvania County maintains that an egg-chicken approach would better serve at risk populations in rural areas of the state. Essentially, the current needs determination process is flawed because it creates artificial barriers for achieving the projected need required to establish a local dialysis facility.

Denying Transylvania County the opportunity to establish a local dialysis facility based solely on projections of in-center patients without consideration of future nursing home populations is not equitable.

Conflicts with Basic Principles

Our petition is based on a number of concerns that are not adequately addressed in the current needs determination process as outlined in Chapter 14 of the *Proposed 2008 State Medical Facilities Plan*. We will now relate those specific concerns to the basic principles underlying the projection of need for additional dialysis stations.

Basic Principle	Conflict
New facilities must have a projected need for at least 10 stations	48% of existing facilities do not meet this standard – additional context and consideration should be provided for dialysis station planning areas without a facility that haven't achieved this threshold
End-stage renal disease treatment should be provided in NC such that patients who require renal dialysis are able to be served in a facility no farther than 30 miles from the patients' homes	As of April 11, 2007, SE Kidney Council, Inc. determined that 6 of 25 patients (24%) were traveling more than 30 miles to a facility. The mileage range for these 6 patients is 31.1 miles to 65.3 miles. The average mileage for all 25 patients is 26.34 miles.

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Reasons for the requested adjustment

Conflicts with Basic Principles (continued)

Basic Principle	Conflict
End-stage renal disease treatment should be provided in NC such that patients who require renal dialysis are able to be served in a facility no farther than 30 miles from the patients' homes	Fails to recognize unique travel challenges in Western NC and mountainous regions. Assertion is that *40 minutes travel time* should be considered as another measure of access based on the assertion that 30 miles of travel in the Piedmont or Coastal regions of the state would not take longer than 40 minutes. As of April 11, 2007, SE Kidney Council, Inc. determined that 16 of 25 patients (64%) were traveling more than 40 minutes to a facility. The travel time range for these 16 patients is 40 minutes to 107 minutes (1 hour, 47 minutes). The average travel time for all 25 patients is 50.36 minutes.
In areas where it is apparent that patients are currently traveling more than 30 miles for in-center dialysis, favorable consideration should be given to proposed new facilities which would serve patients who are farthest away from existing, operational or approved facilities.	Our petition outlines multiple aspects which attest that this basic principle is not being adequately considered: station surpluses in the region, unnecessary station expansion approvals, lack of regional zip code based analysis relative to expansion requests and areas without facilities and failure to consider travel time in conjunction with travel distance
Services in rural, remote areas	It defies logic that Transylvania County is surrounded by dialysis facilities, all with projected station surpluses and is prevented from obtaining a dialysis facility based on the current needs determination process.

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Reasons for the requested adjustment

Statement of adverse effects

The adverse effects relate to the human condition and are defined in several instances in the accompanying letters of support. The greatest adversity is evidenced by the patients enduring the longest travel distances and times. Our hallmark example is the patient traveling more than 65 miles and an hour and 47 minutes (each way), three times a week. The average travel time for all Transylvania County patients as of April 11, 2007 is 50.36 minutes. This travel demand is extreme by any measure and is the core argument of the petition. End-stage renal disease is overwhelming at best, but local citizens are having that circumstance negatively magnified by having to make these extreme commutes three times a week. Several patients have stipulated that they believe the extreme travel demands are exacerbating their condition.

The Department of Public Health has also heard from multiple families who need to relocate a loved one with dialysis needs here, but can't due to the fact that local nursing homes won't consider those individuals based on the significant transportation requirements. Families and loved ones are being separated and in some cases, entire family units are moving out of Transylvania County to accommodate the dialysis needs of a loved one. Support systems including family are crucial to a dialysis patient and the lack of a local facility is creating unreasonable challenges for many families in sustaining that network of support.

In addition, we have already submitted that our terrain and vulnerability to extreme weather conditions have created life threatening situations when travel is suspended for sustained periods of time. Our steep slopes, higher elevations and flood prone zones are particularly susceptible to inclement weather effects.

Statement of alternatives

Based on the challenges and concerns outlined, we see no other reasonable alternative than establishment of a local dialysis facility. Patients are naturally gravitating to the nearest existing facility for dialysis treatment, but the lack of a facility in this jurisdiction is creating unreasonable access barriers for local residents.

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Evidence that unnecessary duplication of health resources would not occur

Transylvania County maintains that establishment of a local dialysis facility would not create unnecessary duplication of health resources based on our local need. If due consideration is provided for our current in-center patient projection, nursing home capacity and improved regional access (proximate zip code analysis for southern Buncombe County and western Henderson County), the cumulative result is an overwhelming and apparent need for a local dialysis facility that would improve cost effectiveness, expand health care services to the medically underserved and provide a quality health care service (basic principles identified in the *Proposed 2008 State Medical Facilities Plan)* to Transylvania County and the immediate vicinity.

Based on the information presented in the *Regional Map of Transylvania County and surrounding counties* (pg. 6), we do believe unnecessary duplication of health resources has occurred, but not in Transylvania County. It is our hope that serious re-evaluation of adjacent county dialysis facility capacity should occur and that the projected station surpluses identified in the *July 2007 NC Semiannual Dialysis Report* should be considered relative to our petition. The regional context advocated for in this petition will better serve the State of North Carolina and Transylvania County in our mutual pursuit of providing equitable access to quality health care services for all.

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Summary

This intent of this petition is to identify specific barriers to establishment of a local dialysis facility based on the current needs determination process outlined in the *Proposed 2008 State Medical Facilities Plan*. The process is challenged in this petition because Transylvania County finds that the methodology and its application are inappropriate and/or inadequate for characterization of our local need based on unique circumstances. The petition follows the basic format outlined in Chapter 2 of the *Proposed 2008 State Medical Facilities Plan*.

Although Transylvania County takes issue with the current needs determination process, it is important that we acknowledge no particular methodology would be perfect or comprehensive for all jurisdictions. It is also evident that circumstances affecting utilization rates for dialysis facilities are dynamic and can't be predicted into the future with any accuracy. That is one of the reasons why we criticize the current needs determination process which places an inordinate focus on achieving 32 in-center dialysis patients (projected need) to be able to proceed with a certificate of need application. Since 48% of existing dialysis facilities in the state are operating below this utilization rate, it is self evident that achieving this threshold is not a reliable indicator that it can be sustained.

Transylvania County's petition clearly outlines a definitive case of need for a local dialysis facility. Extreme travel distances, extreme travel times, segregation of families and the associated hardships placed on patients and their families highlight a dire situation. Many of the letters of support attest to these hardships and challenges. In addition, the regional issues that accompany our petition support a more realistic approach for decisions about dialysis facility expansions and new facilities. Although no perfect model exists, enhanced incorporation of regional factors including station surpluses should be considered as part of the "big picture" for future designations of new facilities.

It is certainly appropriate to conclude our petition by relating our position back to some of the founding legislation for the Certificate of Need process and the associated development of the State Medical Facilities Plan. NCGS 131E-175 has several passages that are relevant to our case including:

- "...citizens need assurance of economical and readily available health care"

While the current Certificate of Need process strives to promote cost effectiveness, we maintain that the "cost" to our local dialysis patients is simply too high and is certainly not "readily available". We do not believe that establishment of a

Summary (continued)

dialysis facility in Transylvania County would negatively impact the cost of dialysis care in North Carolina.

- a concern that if left to the market place "...geographical maldistribution of these facilities and services would occur..."

We maintain that geographical maldistribution of facilities has occurred as outlined on the Regional Map on page 6. The projected station surpluses for surrounding counties in our region are extraordinary and due consideration should be given to reallocation of those resources to Transylvania County.

- "that access to health care services and health care facilities is critical to the welfare of rural North Carolinians, and to the continued viability of rural communities, and that the needs of rural North Carolinians should be considered...."

We couldn't agree more. This petition hopes to achieve that very goal. If this mandate is duly considered in conjunction with an objective review of the material contained within this petition, we sincerely believe that our case merits a recommendation from the North Carolina State Health Coordinating Council to adjust the need determination for Transylvania County and to accordingly amend the *Proposed 2008 State Medical Facilities Plan.*

Appreciation

Most importantly, we owe our appreciation to the stalwart dialysis patients in Transylvania County (past and current) and the multiple individuals, professionals and families involved in their daily care and transportation. We also thank the individuals, agency representatives and elected officials that graciously provided letters of support and to the community at large for their support of this petition. We would also like to commend the Medical Facilities Planning Section and the NC State Health Coordinating Council for their time and consideration of this petition and trust they will find this proposal to be a compelling and definitive case of need to establish a local dialysis facility in Transylvania County.

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Documents

- **April 11, 2007 SE Kidney Council, Inc. Report on Travel Distance and Travel Time of Transylvania County Patients and e-mail**

  *** See next two pages**

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

E-mail to Steve Smith. dated April 11,2007, 3:51pm

Your request has been processed and is data is attached. As discussed an invoice for the $75.00 will be forward to you from our Administrative Department Please feel free to contact me if there are questions concerning this data

<<Transylvania Travel Information doc>>

Diana Lucas
Information Management Coordinator
Southeastern Kidney Council, Inc.
1000 St. Albans Drive
Raleigh, North Carolina 27609
Voice (919) 855-0882 Fax(919) 855-0753
www.esrdnetwork6.org

Southeastern Kidney Council, Inc. Travel Analysis

Patient's Facility	Travel Time	Distance to Facility (Miles)
Patient A	33	23.4
Patient B	47	22.7
Patient C	33	23.4
Patient D	34	15.5
Patient E	40	19.8
Patient F	52	23.8
Patient G	39	19.2
Patient H	1hr 2 min	31.1
Patient I	34	16.1
Patient J	38	17.8
Patient K	36	16.8
Patient L	46	21.9
Patient M	52	23.8
Patient N	43	21.2
Patient O	1 hr. 11 min	46.9
Patient P	43	21.1
Patient Q	1 hr 47 min	65.3
Patient R	52	23.8
Patient S	43	21.2
Patient T	44	21.2
Patient U	33	23.4
Patient V	1 hr. 9min.	37.1
Patient W	1 hr 28 min.	54.6
Patient X	37	17.3
Patient Y	1 hr 23	51.3

Travel Time for Transylvania County Patients
Prepared April 11, 2007

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

Letters of Support

See attached.

HEATH SHULER

Congress of the United States

House of Representatives

Washington, DC 20515–3311

July 12, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

To Whom It May Concern:

I am writing to express my support for Transylvania County's petition to establish a local dialysis facility.

The petition cites a number of compelling reasons why a new facility is needed in the county. Of the county's 25 current dialysis patients, many are required to travel over 30 miles and one patient over 65 miles each way, three times per week. This creates a significant burden of time and cost for these patients and their families. The mountainous terrain and associated inclement weather can also limit a patient's ability to travel and obtain necessary treatment.

Perhaps most importantly, the county's local nursing home facilities are unable to accept dialysis patients because of the lack of a local facility. Families are therefore forced to relocate loved ones to nursing homes far from home and closer to dialysis facilities. A local facility would greatly reduce these various risks and burdens, while reflecting a higher and more accurate number of Transylvania patients in need of such a facility.

I ask that you give this petition your most thoughtful and serious consideration. If you need additional information, please contact Tom Jones in my district office at 828-252-1651 extension 15.

Thank you very much for your time and attention to this matter. Please do not hesitate to contact me if I may be of assistance as you make your determinations.

Sincerely,

Heath Shuler
Member of Congress
11th District, North Carolina

North Carolina General Assembly
Senate

SENATOR JOHN J. SNOW, JR.
50TH DISTRICT

OFFICE: 2111 LEGISLATIVE BUILDING
16 W JONES STREET
RALEIGH, NC 27601-2808

PHONE (919) 733-7978
(919) 754-3348 FAX

EMAIL johnsn@ncleg.net

DISTRICT: 50TH

CHEROKEE JACKSON
CLAY MACON
GRAHAM SWAIN
HAYWOOD TRANSYLVANIA

COMMITTEES:

CO-CHAIR
APPROPRIATIONS ON JUSTICE AND PUBLIC SAFETY
MEMBER
AGRICULTURE/ENVIRONMENT/NATURAL RESOURCES
APPROPRIATIONS/BASE BUDGET
EDUCATION/PUBLIC INSTRUCTION
JUDICIARY II (CRIMINAL)
MENTAL HEALTH/YOUTH SERVICES
TRANSPORTATION
JOINT SELECT COMMITTEE ON EMERGENCY PREPAREDNESS AND DISASTER MANAGEMENT RECOVERY

July 11, 2007

Dr. Dan Myers
Chairman
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

RE: Transylvania County Dialysis Facility

Dear Dr. Myers,

I am writing you a letter in support of Transylvania County's petition for an End-State Renal Disease Dialysis Facility. In order to best help the citizens of North Carolina, I believe it is imperative that Transylvania County's petition should be approved. I further believe the stipulations placed upon Transylvania County go beyond reasonable.

As of the beginning of the year, only 78 of 149 certified facilities were operating at or above 80% utilization. I do not think it is fair to require Transylvania County to operate at a level of utilization that surpasses 48% of the certified facilities.

After looking at the figures, I have also noticed that many patients who would be served by this facility are traveling either close to or above an hour each way. This is an unfair burden on the rural at risk populations in North Carolina. As of April of this year, 24%

of the patients of the SE Kidney Council Inc. were traveling more than 30 miles for treatment with many traveling over an hour one way.

Likewise because of the areas vulnerability to extreme weather and terrain, many of these patients would be placed in a perilous situation in the event that travel is suspended for any period of time. If approved, this facility would reduce much of the life threatening ramifications the weather and terrain present. We must do more for the rural citizens of North Carolina.

Please support Transylvania County's petition for an End-State Renal Disease Dialysis Facility. I thank you for your time on this matter.

Sincerely,

Sen. John J. Snow, Jr.

North Carolina General Assembly
House of Representatives

REPRESENTATIVE TRUDI WALEND
113TH DISTRICT - TRANSYLVANIA, POLK & HENDERSON

OFFICE: 16 W. JONES STREET #1015
STATE LEGISLATIVE BUILDING
RALEIGH, NC 27601-1096
PHONE: (919) 715-4466
FAX: (919) 754-3228
E-MAIL: trudiw@ncleg.net

HOME: 147 RIDGEWOOD PLACE
BREVARD, NC 28712-9561
PHONE: (828) 883-3790

COMMITTEES
ENERGY & ENERGY EFFICIENCY - VICE CHAIR
FINANCE
HEALTH
INSURANCE
JUDICIARY III
STATE PERSONNEL
WAYS & MEANS

June 30, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Hello.

I strongly support Transylvania County's petition to establish a local dialysis facility in our county.

As the State House Representative for Transylvania County and a resident of Transylvania County, I am greatly concerned about access to a dialysis facility for patients who must cope with our unique mountainous geography and associated travel challenges. Our county is located a long distance from the nearest interstate increasing travel time. When combined with inclement weather (ice, snow, floods) this creates life threatening conditions for vulnerable dialysis patients.

Local nursing homes are not able to consider caring for dialysis patients due to the burden of transporting them to out-of-county facilities. This requires families to be separated from their loved ones.

I am very encouraged about a proposed dialysis facility in Transylvania County and support the increased access of quality medical service it will bring. My constituents, area health care providers, and I enthusiastically and fully support this petition.

Thank you for your consideration.

Sincerely,

Trudi Walend

Trudi Walend

7-10-07

To Whom it may Concern:

Having a Dialysis Center in Brevard or Transylvania County would certainly be a great help for my family.

My husband has been a kidney dialysis patient for four years. Having to drive to Hendersonville and back three times a week, in all kinds of weather, is not a pleasant task.

Since the price of gasoline has risen so drastically, you can imagine the extra hardship that causes -

We would be very grateful for your consideration in getting a dialysis center here.

Sincerely yours,

Wilma Hornbuckle
P.O. Box 2181
Brevard, NC 28712

Steven E. Smith, M.P.A.
Health Director

Timothy J. Shea, M.D.
Medical Director

Transylvania County Department of Public Health

July 10, 2007

Medical Facilities Planning Section
Division of Facility Services – NC Department of Health and Human Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Re: Letter of Support for Transylvania County – Petition to Establish Local Dialysis Facility

To The North Carolina State Health Coordinating Council:

On behalf of the Transylvania County Board of Health, I would like to provide our endorsement of the petition to adjust the need determination incorporated within the *Proposed 2008 State Medical Facilities Plan* so that Transylvania County may proceed with a Certificate of Need application to establish a local dialysis facility. This is a public health issue of great significance for our community and it is imperative that our citizens obtain reasonable access to this vital health care service.

The board has discussed the basis of the petition on several occasions and shares the same concerns about our present circumstances including:

- Inequity of having to achieve a projected need which exceeds the utilization rate of 48% of the existing dialysis facilities in order to proceed with a Certificate of Need application
- Inequity of substantial station surpluses in surrounding counties in the region and not having resources reallocated here
- Adverse effects on current dialysis patients and their families including exceptional travel distances and times and the segregation of families due to the inability of nursing homes to accept dialysis patients without a local facility

These circumstances reflect the fact that due consideration has not been provided in the current need determination process relative to the welfare of rural Transylvania County residents. We have a right to reasonable access to health care services and urge you to approve a revised determination of need for a dialysis facility in order for this critical piece of health care infrastructure to be established in Transylvania County. Our mission is to protect and promote public health in Transylvania County and the board sincerely believes that a local dialysis facility is needed to accomplish that objective.

Thank you in advance for your consideration of our petition. Please feel free to contact me if you have any questions about this correspondence.

Sincerely,

J. Hooper Williams, OD
Chairperson – Transylvania County Board of Health

cc: Transylvania County Board of Health

Brian Center
Health & Rehabilitation

To Whom It May Concern:

I understand that there is consideration being given to expanding the dialysis center in Henderson County. I truly believe that expansion is necessary but I would suggest that it be considered for Transylvania County. Currently there is not a dialysis center in Transylvania County and this causes great hardship for the residents of this county needing this service.

As a nursing home administrator, I am forced to decline admitting patients needing our services if they also require dialysis. I am unable to provide transportation to and from Henderson or Buncombe County for dialysis. There is not a non-emergency transportation agency in Brevard making it even more difficult. If one of my patients goes to the hospital and ends up needing dialysis, I am unable to re-admit them.

While this is a problem for the patient, it is also of great concern to the family members involved. I don't think anyone wants to have their elderly mother of father in a nursing facility 25-35 miles away. I think it is a shame that many elderly residents of Transylvania County must be cared for in other counties due to the lack of this service.

I would urge you to please give this some consideration.

Sincerely,

Sue Harris Robinson
Administrator
Brian Center Health and Rehabilitation/Brevard

531 Country Club Road ■ Brevard, North Carolina 28712 ■ Tel: 828-884-2031 ■ Fax: 828-884-2831

Transylvania County Schools

Career-Technical Education
Transportation Services
Southern Association of Colleges and Schools

747 Country Club Road
Brevard, NC 28712
Ph: 828-884-4188 – Fax: 828-885-7359

June 28, 2007

To Whom It May Concern:

I am writing out of concern for dialysis patients in our community. I understand that a public hearing is to be held on July 13, 2007. At this hearing Transylvania County will petition the North Carolina State Health Coordinating Council for a local dialysis facility to be located and built in the county. I ask that you please honor this request.

Certainly, numbers used for validation normally suggest that a county should have at least 32 patients in order to qualify for a new dialysis facility. Transylvania County currently has 25 patients. However, this number has steadily increased from a count of 19 in 2003. Unfortunately, as our population here continues to age and with a continual growth in both general population and the number of retirees locating here, that number will most assuredly increase.

Although numbers are the rule of discretion, I encourage the Council to place a face and a family with each and every one of these 'numbers' needing treatment. Many of our current dialysis patients commute over an hour and twenty minutes roundtrip, three times a week for services. Several have even longer commutes involving over 60 miles roundtrip. Transylvania County does not have the convenience of flat land and straight highways. Our topography includes elevations that range from under 1300 feet above sea level to over 6000 feet. The headwaters of the French Broad River are located in the county along with an abundance of rivers, creeks and streams, that while beautiful and appreciated, provide a backdrop for one of the wettest counties east of the Mississippi. Roads are routed around many natural obstacles causing greater travel challenges.

There are no major highways connecting the county to larger metropolitan areas and the nearest interstate is approximately 20 miles from our largest town. Transylvania County is also home to some of the most diverse weather in the mountains. These conditions over the years have created life threatening situations for vulnerable dialysis patients due to restricted travel. Statistical information current as of June 30, 2006 show that only 52% of certified facilities in North Carolina were operating at or above 80% utilization. This seems to indicate that 48% of the certified facilities already operating in NC are functioning below the level required of us to establish a new dialysis facility.

But it is the faces of those directly affected that I must return to. Cold statistics and numbers can never tell the stories of real hardship or disruption of lives. Dialysis patients here in Transylvania County must endure the hardship of a long commute to Hendersonville three times a week every week. It is commonplace for the entire process

to take well over seven to eight hours per day, and this is assuming that all other conditions, including traffic and safety are conducive.

As a concerned citizen, public servant, veteran school educator, and friend and neighbor to those suffering from kidney diseases, I ask that serious consideration be given for a Dialysis facility for Transylvania County.

Thank you for your time and consideration.

Sincerely,

Jeff McDaris

Jeff McDaris, Ed.D.
Director – Career-Technical Education
Director – Transportation Services
AdvancEd Accreditation Liaison
Transylvania County Schools

Member – Mountain Area Workforce Development Board
Trustee – Blue Ridge Community College

COUNTY MANAGER
Arthur C. Wilson, Jr.
828-884-3100
Fax 828-884-3179
828-884-3117
21 East Main Street
Brevard, NC 28712

Transylvania County

June 27, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Ref: Letter of Support for Transylvania County-Petition to establish Local Dialysis Facility

Dear Sirs:

As Chairman of the Board of Commissioners of Transylvania County I hereby request that you consider allowing a local dialysis treatment facility to be located in Transylvania County. Currently six of the twenty five patients from Transylvania County are traveling more than thirty miles each way to a dialysis facility. Thirty miles is listed as the preferred maximum traveling distance for dialysis patients in the State Medical Facilities Plan. One patient travels more than sixty fives miles each way. These trips are made by these patients three times a week. Sixteen of the twenty five patients from Transylvania County are traveling more than forty minutes each way to a dialysis facility. Considering the geography of our county where one can go from a level of 2,350 feet to a height of 6,000 feet presents serious challenges to our residents to get to the nearest dialysis facility in an adequate time frame especially during inclement weather such as snow, ice and floods.

Local nursing home facilities are not able to consider dialysis patients at this time due to the enormous burden of transporting patients to out of county facilities. This separates families and creates barriers for other families that want to relocate loved ones to local nursing homes. As of June 30, 2006, only 52% of certified facilities in North Carolina were operating at or above 80% utilization. This means that 48% of the certified facilities operating in NC are functioning below the level required of us to establish a new dialysis facility in our county.

Transylvania County continues to be rated as one of the hot spots for retirement in the United States. With an aging community we need to have a dialysis facility located in our county.

Sincerely,

Jason R. Chappell, Chairman
Board of County Commissioners

acw

Cc: Members, Board of Commissioners
County Manager
Health Director
File

June 27, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

LETTER OF SUPPORT FOR TRANSYLVANIA COUNTY-PETITION TO ESTABLISH LOCAL DIALYSIS FACILITY

To Whom It May Concern:

I am writing in support of the establishment of a local dialysis center in Transylvania County.

Statistics show that 6 of the current 25 dialysis patients in our County are traveling more than 30 miles each way to a dialysis facility. 16 patients travel more than 40 ~~miles~~ minutes each way. One patient travels more than 65 miles each way. We must remember that these patients have to endure this commute 3 times a week.

Local nursing homes are currently unable to consider dialysis patients because they do not have enough staff or adequate transportation to take patients to out-of-county centers. Additionally, inclement weather, including snow, ice, flooding, has created life-threatening situations for dialysis patients because they simply cannot navigate dangerous roads and driving conditions.

I am aware that 48% of the certified facilities operating in NC are functioning below the level required of us to establish a new dialysis facility. Considering the aging population of Transylvania County, I feel certain that the numbers of people requiring dialysis will grow rapidly.

I am passionate in my support. My mother-in-law had to undergo the inconvenience of traveling to dialysis centers in Henderson and Buncombe Counties for more than 4 years before her death. There were times when she was so weak and ill that she had to lie down in the car. You can imagine the emotional burden our family felt to see her suffer. At the same time we were caring for our father with dementia and immobility. What a blessing it would have been to be able to go to a local center.

Please carefully evaluate the immediate need to establish a center in Transylvania County on behalf of the patients and their families.

Thank you,

Phyllis Blunt

Phyllis Blunt, Board Member
Transylvania Christian Ministry/Sharing House
Brevard, NC

COUNTY MANAGER
Arthur C. Wilson, Jr.
828-884-3100
Fax 828-884-3119
828-884-3107
21 East Main Street
Brevard, NC 28712

Transylvania County

June 29, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Ref: Letter of Support for Transylvania County-Petition to establish Local Dialysis Facility

Dear Sirs:

As the County Manager of Transylvania County I hereby request that you consider allowing a local dialysis treatment facility to be located in Transylvania County. Currently six of the twenty five patients from Transylvania County are traveling more than thirty miles each way to a dialysis facility. Thirty miles is listed as the preferred maximum traveling distance for dialysis patients in the State Medical Facilities Plan. One patient travels more than sixty fives miles each way. These trips are made by these patients three times a week. Sixteen of the twenty five patients from Transylvania County are traveling more than forty minutes each way to a dialysis facility, that is, if it is a good weather day. Being located in the mountains presents problems with snow, ice, and floods since we are on the headwaters of the French Broad River.

Local nursing home facilities are not able to consider dialysis patients at this time due to the enormous burden of transporting patients to out of county facilities. This separates families and creates barriers for other families that want to relocate loved ones to local nursing homes. As of June 30, 2006, only 52% of certified facilities in North Carolina were operating at or above 80% utilization. This means that 48% of the certified facilities operating in NC are functioning below the level required of us to establish a new dialysis facility in our county.

Transylvania County continues to be rated as one of the best locations for retirement in the United States. With an aging community we need to have a dialysis facility located in our county.

Sincerely,

Arthur C. Wilson, Jr.
County Manager

Cc: Health Director

LETTER OF SUPPORT FOR TRANSYLVANIA COUNTY PETITION TO ESTABLISH LOCAL DIALYSIS FACILITY

29 June 2007

Mr. Steve Smith
Transylvania County Dept. of Public Health
98 East Morgan St.
Brevard, NC 28712

Mr. Smith,

I would like to add my support to your petition for a dialysis facility in Transylvania County. Currently, I have a 50-year-old brother living in California with our 81-year-old mother. My brother has been receiving dialysis three times a week for about four years, and my mother is his only caregiver. This situation is no longer tenable, as both of their health continues to deteriorate.

My mother has been visiting me for the last week, and during that time we have explored alternative living arrangements in this area. Because of my brother's need for dialysis, and the requirement that he be transported out of the county for that treatment, we have not been able to make plans to have our family living near each other.

Please consider the petition favorably, as having a dialysis facility here would allow my family and me (and others, I am sure) to keep our loved ones close to home in their time of need.

Kurbie Whitehead
109 Rocky Hill Overlook
Brevard, NC 28712
(828)883-8153

1291 Cherrywood Lane
Pisgah Forest, NC 28768

July 2, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Gentlemen,

I am writing in support of locating a local dialysis facility in Transylvania County.

Reasons for such a facility are:

- 6 of the current 25 patients from Transylvania County are traveling more than 30 miles (each way) to a dialysis facility (*30 miles is listed as the preferred maximum traveling distance for dialysis patients in the State Medical Facilities Plan) – one patient travels more than 65 miles each way (remember patients have to endure this commute 3 times a week)
- 16 of the current 25 patients from Transylvania County are traveling more than 40 minutes (each way) to a dialysis facility (*a preferred maximum travel *time* is not listed in the State Medical Facilities Plan – we believe that approach fails to consider the unique geography of mountainous counties and associated travel challenges)
- Local nursing home facilities are not able to consider dialysis patients at this time due to the enormous burden of transporting patients to out of county facilities – this separates families and creates barriers for other families that want to relocate loved ones to local nursing homes
- Inclement weather (snow, ice, floods) in Transylvania County has created life threatening situations for vulnerable dialysis patients due to restricted travel
- As of June 30, 2006 , only 52% (77 certified facilities out of 147) were operating at or above 80% utilization (3.2 patients per station or 32 patients for a minimum of 10 stations) – this means that 48% of the certified facilities operating in NC are functioning below the level required of us to establish a new dialysis facility

Please consider this request at you July 13th hearing.

Sincerely,

Bruce F. Semans

Bruce F. Semans
Board of Directors
Transylvania County Volunteers in Medicine

Letter of Support for Transylvania County—Petition to Establish Local Dialysis Facility

576 White Squirrel Lane
Brevard, NC 28712
July 2, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Dear Sir/Madam:

I would like to add my name to the growing list of petitioners asking you to consider the need in Transylvania County for a dialysis facility. I am a retired college professor now engaged in extensive volunteer work with non-profits in our county and am presently Vice President of the Board of Transylvania Christian Ministry, our county's only comprehensive food pantry, clothing, and crisis management facility for the poor, known locally as Sharing House.

In my work with Sharing House I have become aware of the growing number of dialysis patients here—presently at 25—who travel sometimes great distances to Henderson County for dialysis three times a week. We have mountainous roads, snowy and icy winter weather, and high gasoline prices to further complicate what is at best an exhausting schedule for most families.

Our number of dialysis patients will, no doubt, vary. But we are a retirement area with an increasing number of aged citizens. I understand that as of June 30, 2006, only 52% of North Carolina dialysis facilities were operating at or above 80% utilization (32 patients at 10 stations). Therefore, I ask you to reconsider the qualifications of our county.

I had very personal involvement with this distance problem when a friend from church required dialysis several years ago. A team of drivers was recruited from among church members, including my husband who regularly drove [redacted] to the Henderson County facility for over a year. This was very, very stressful for the Johnson family.

Thank you for considering my letter as you evaluate the need for a dialysis facility in Transylvania County.

Yours truly,

Marcia M. Harper

Dr. Marcia M. Harper, Associate Professor of English, Retired

George Robert McCormick
154 Creekstone Drive
Brevard, NC 28712
July 3,2007

"Letter of Support for Transylvania County-
Petition to Establish Local Dialysis Facility"

To Whom It May Concern;

I would like to have access to a local dialysis facility in Transylvania County, North Carolina. Having to travel to Hendersonville, North Carolina three times a week is very stressful and quite time consuming. My wife and I live outside the city limits of Brevard, North Carolina and need to Begin getting ready for the trip before 2:00 p.m.. I meet the County Transportation van just after That time for the trip to Hendersonville. Arriving at the center in Hendersonville just before 3:30 p.m., I am then prepared for a four hour treatment on the machine. Yesterday, July 2nd, for instance, the machine wasn't available until about 4 p.m. which put me getting through after 8 p.m.. In the meantime, my wife needs to drive from our home to the Hendersonville facility to Await my release, whenever that may be. It is usually after 9:00 p.m. when we arrive back home.

For your interest, I am 73 years of age and my wife is 68. So we are not really up for the stress And activity required for all this. The expense of driving back and forth to Hendersonville three times a week in our personal vehicle is also a hardship as we are both living on pension and Social Security.

Please give us the help we need. If you need more information, please feel free to contact me at (828) 883-5551.

Sincerely,

George Robert McCormick

George Robert McCormick

Mr. Smith:

My name is Debra Ann Sue Smith & my husband [redacted] was one of your dialysis patients he passed away on Oct 20-2005, he went back & forth to Hendersonville 3 days a week, sometime this was very hard on him, as for your nurses & home health I know just how they are, maybe they didn't mean to but when he was a dialysis patient, he & I are all your's until the end @ TCH

Thank you
Debra Ann Sue Smith

July 9 2007

Steve Smith
Director
Department of Public Health
Transylvania County

Dear Mr. Smith:

I understand the county will be petitioning the North Carolina State Health Coordinating Council on July 13 for the right to establish a dialysis facility in the county. That would be a wonderful thing.

I'm 75 and I drive 45 miles round trip to the Hendersonville dialysis center three days a week. Traffic is sometimes heavy and hectic on the two-lane Route 64. I spend almost 1½ hours on the road.

A number of dialysis patients and nurses and nurse-type employees also live in Transylvania County.

Best regards Robert Voelker
Bob Voelker
6 Kaden Ln
Brevard N.C.

LAND OF WATERFALLS
Partnership for Health

6 July 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

I write in support of the petition of the Transylvania County Health Department to establish a local Dialysis Facility.

There is an overwhelming need for such a program in Transylvania County. The number of patients needing a dialysis facility is steadily increasing as the population of the county increases. Improved access to diagnostic capability increasingly identifies a growing number of patients who would benefit from local dialysis services.

Of particular concern is the fact that mountainous terrain in Transylvania County makes travel time, especially in winter months, a significant factor. The State Medical Facilities Plan fails to consider the unique geography of North Carolina's mountainous counties and the associated travel challenges. Most of the current patients must travel in excess of 40 minutes to reach a dialysis center. A round trip doubles that time and must be endured three times each week. Add to that time spent traveling, in the best of weather and often at county expense, to the often inclement weather and it adds up to a situation that is frequently life-threatening for the vulnerable dialysis patients.

As Transylvania County becomes more and more attractive to retirees, the age demographic increasingly skews toward an older population. Inevitably many in that population cohort must seek a skilled nursing facility. The absence of a local dialysis facility means that patients needing dialysis cannot be accepted in local long-term care, rehabilitation, or skilled nursing facilities. A sad result is that such patients must be placed in out of town facilities. This in turn leads to a disruption in the family support networks often so vital to the quality of life for such patients.

If considered only on a fairness basis in comparison to other North Carolina counties, it must be noted that in flatter terrain the State Medical Facilities Plan mandates a maximum travel distance, not time, of 30 miles. Therefore, in many counties and for many North Carolinians, a trip to a dialysis center is relatively quick. Add the fact that nearly half of the current North Carolina dialysis centers operate at a patient load below the level required of Transylvania County to establish a new dialysis facility. It is clear that basic fairness alone should compel the approval of a facility here.

The Land of Waterfalls Partnership for Health has determined through its community healthcare assessment that access to care is a critical need in Transylvania County. We believe that a local dialysis center is a necessary part of insuring that our residents have the same access to care as that enjoyed by other citizens of the State. We support it enthusiastically.

Sincerely,

Michael J. Ziegler
Executive Director

230 Morgan Street
Brevard, NC 28712

July 9, 2007

Medical Facilities Planning Section
NC Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Letter of Support
Transylvania County Petition to establish local Dialysis Facility

Medical Facilities Planning Section,

On behalf of the Town of Rosman and the Board of Aldermen, I would like to voice our unequivocal support for Transylvania County's petition to establish a local dialysis facility. This is a tremendous need for citizens of our county and I am personally aware of individuals in our jurisdiction that have dialysis treatment needs.

The travel distances and travel time being endured by these individuals three times a week is unacceptable. The debilitating effects of end stage renal disease are exacerbated for this specific population by also having to manage long commutes. 9 of the current 25 dialysis patients travel more than 30 miles each way, 16 of the current dialysis patients travel more than 40 minutes each way. In addition to this challenge, families are being separated because loved ones can not be established in local nursing homes. Local nursing homes can not currently consider housing dialysis patients due to the tremendous burdens associated with transportation of these individuals to other counties three times a week.

Transylvania County needs and deserves a local dialysis treatment facility to better serve our citizens and community. Please give every consideration to Transylvania County's petition to establish a dialysis facility.

Sincerely,

Michael Owen, Mayor
Town of Rosman

cc: Board of Aldermen

July 7, 2007

TO WHOM IT MAY CONCERN

Re: Letter of Support for Transylvania County - Petition to establish a local Dialysis Facility

The following points support our reason for this petition for a local dialysis facility in our county.

1. The well-being of the patient in being able to have dialysis treatment near home would make a big difference in many ways. The travel time, and many, many other benefits to patients and their family members.

2. We have in place local Doctors and staff to operate a dialysis facility and care for the patients.

3. In that we are in a area that so many people visit,or spend their vacation etc., having a dialysis facility would be beneficial to those visiting patients.

Signed: Rhonda Turk, Date: 7/9/07

Note: Family Member of: [redacted]

Steve Smith

From: Katinka Haines [kphaines@citcom.net]
Sent: Monday, July 02, 2007 10:35 PM
To: Steve Smith
Subject: Fwd: Dialysis

From: Katinka Haines <kphaines@citcom.net>
Subject: Fwd: Dialysis

Date: Sat, 30 Jun 2007 23:43:46 -0400
To: steve.smith
From: Katinka Haines <kphaines@citcom.net>
Subject: Dialysis

Not only does it do my heart good to think that we may get dialysis treatment here in our wonderful county but personally, I am most eager to see it actually happen.
My husband was given the bad news 2 weeks ago that that is in his near future.
Presently, Hendersonville has the closest treatment.
As he will have to go at least 3 times a week, not only is that a hardship time-wise but with the cost of gas.....we are very worried.
We are most fortunate with our hospital which even has the MRI.
Please work hard for a dialysis facility.
Thank you.
Katinka P. Haines

Steve Smith

From: Dorothy Geiser [daps@citcom.net]
Sent: Sunday, July 08, 2007 11:25 AM
To: Steve Smith
Subject: Dialysis Support Letters

LETTER OF SUPPORT FOR TRANSYLVANIA COUNTY PETITION TO ESTABLISH LOCAL DIALYSIS FACILITY [redacted] - 77 years old - dialysis patient Dorothy Geiser - 74 years old - wife of patient Phone # 884-2209

Hardships since [redacted] was put on dialysis in March 2007

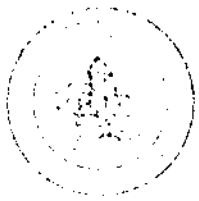
1. When emergency arose to put [redacted] on dialysis, he had to be transported to Mission Hospital because local hospitals did not have dialysis centers (1 hour a day travel to see him for 12 days).

2. When [redacted] needed a rehab stay after hospitalization he had to go to Brian Center in Hendersonville because Brevard facilities would not transport him, (1/2 hour away).

3. His hours on dialysis are 4:00P.M. to 8:00P.M. and Brian Center would not transport him after 5:00P.M. I had to provide transportation at $60 a trip (which was 3 miles) to dialysis, $180 a week. I'm glad it was only 20 days and one night they forgot him and I had to come from Brevard at 9:00 P.M. to get him back to Brian Center.

4. We are on a waiting list to change dialysis hours. I hope it comes through before winter and dark nights.

We receive free transportation to dialysis in Hendersonville from Transylvania Community Services which we are extremely grateful for and then I pick him up at 8:00P.M. which seems to be the only benefit there is if you are on dialysis and live in Brevard.



COUNTY MANAGER
Arthur C. Wilson, Jr.
828/884-3100
FAX 828/884-3119

28 East Main Street
Brevard, NC 28712
828/884-3107
FAX 828/884-3119

Transylvania County

July 9, 2007

To Whom It May Concern:

I am writing in support of Transylvania County seeking the Certificate of Need for the right to establish a dialysis center. I am currently the medical transportation coordinator for Transylvania County Transportation. Prior to this position I was the Med-Drive coordinator for Home Care at Transylvania Community Hospital. Thus, for over 13 years I have received urgent requests for dialysis transportation. As I am sure you recognize, dialysis and transportation go hand in hand for our residents; without transportation they cannot receive dialysis, and without dialysis they will lose their life.

About 5 years ago Transylvania County became blessed to be able to establish a van route for dialysis. With the van service we have been able to accommodate more clients and provide wheelchair access. However; this additional service meant that our clients have a longer travel time, and very close and cramped seating. There was also a loss of a few seats due to wheelchairs, O2 containers, and other medical apparatus that our clients need to transport due to the extended amount of time required away from their homes for dialysis.

Currently we are transporting 10 clients, and receiving new referrals on a regular basis. We are now providing 2 routes for dialysis. Frequently clients may have complications such as "bleeding out", nausea, motion sickness, and a number of other things that may cause unavoidable delays for their return trip home.

The day is very long and exhausting for these clients, not only physically draining but emotionally as well. Words cannot even begin to express the sadness one feels when a client has had such a toll taken on them by the trip that they have opted out of dialysis, speeding up their own death. We have also had families move to Henderson County just to make dialysis easier to bear physically, emotionally, and financially. When the decision of nursing home placement comes up for the client, the only option they have is in Henderson County. Our local nursing homes do not accept dialysis clients due to the distance of the dialysis center.

It is no secret that Transylvania County is becoming an increasingly aging community. Also, with people going on dialysis more frequently and often at younger ages, it only makes sense that our numbers will continue to grow. If you also take into account the residents that we are losing to Henderson County by relocation and nursing home placement, I am certain that we are well within the numbers that are needed for a dialysis center. I urge you to please award the Certificate of Need to Transylvania County. Our residents deserve easier access to health care that is truly life saving.

Sincerely,

Lisa McDaris

Lisa McDaris
Medical Transportation Coordinator

COUNTY MANAGER
Arthur C. Wilson, Jr.
828/884-3100
FAX 828/884-3119

28 East Main Street
Brevard, NC 28712
828/884-3107
FAX 828/884-3119

Transylvania County

July 6, 2007

To Whom It May Concern:

I am writing in support of the dialysis patients of Transylvania County. It is my understanding that a public hearing on dialysis treatment for the citizens of the county is scheduled for July 13, 2007. At this meeting, a petition for a dialysis facility will be presented to the North Carolina State Health Coordinating Council. I ask that this request be honored.

As Transportation Coordinator for Transylvania County, I oversee services for our citizens in need of dialysis treatment. These services are focused on the transportation of patients to Hendersonville three times a week. This distance places additional health difficulties on our patients, and serves to further highlight the need for this life-saving assistance to be provided in the county.

A Dialysis facility located here will allow us to provide transportation to a larger number of clients. Presently, we are only able to provide two travel opportunities to our citizens requiring dialysis on Monday, Wednesday, and Friday. Locating a dialysis center in Transylvania would accomplish the following:

1. Serve our clients more efficiently;
2. Serve additional clients; and
3. Allow us to expand our assistance to patients to include Tuesdays and Thursdays.

Many of the clients we serve in this capacity eventually become residents of nursing homes and assisted living facilities. Unfortunately, nursing homes in our county do not accept patients needing dialysis. This places an additional burden on dialysis clients in need of a nursing home's services. For this, they must locate a nursing home out of the county in which to live, which further separates them from their family and friends. A center located here would eliminate much of this growing dilemma.

Our county is experiencing a rise of both our senior citizen population and the number of residents requiring dialysis treatment. Our need is growing exponentially. I ask that a kidney dialysis treatment center be strongly encouraged and supported.

Sincerely,

Keith McCoy

Keith McCoy
Transportation Coordinator

KM: sh

TRANSYLVANIA COMMUNITY HOSPITAL

Right Choice. Right Here.

To whom it May Concern;

I am writing in support of the petition initiated by Transylvania County for a local dialysis facility. I am a native of Transylvania County and have served in many roles at Transylvania Community Hospital in the past 17 years. Two roles in particular heightened my awareness for the need of local dialysis services.

During the five years I served as Hospice Manager, I worked with many patients and their families facing end stage renal disease. The patients had already made the decision to stop dialysis treatments or were in the process of making that decision. A recurring barrier for these patients to continue treatments was the extended trip out of the county for the service. Some families had the additional financial resources and community support to make the trips, but many patients relied on the transportation system offered through Transylvania County Transportation Department. The patients/families were very appreciative, but the trip, at best was difficult and in some cases could even contribute to complications related to dialysis.

I currently serve as the Manager for the Case Management Department at Transylvania Community Hospital. In this role, I have seen a different perspective to the issue. Without a local dialysis center, the dialysis patients in need of acute hospital care are transferred to either Asheville or Hendersonville, thus taking them further away from their families and community support. Dialysis patients in need of skilled nursing services are also unable to stay in Transylvania County due to transportation issues.

A dialysis center would allow more patients to receive on going health care in their local communities including physician services, inpatient and outpatient hospital services and skilled nursing services. With an aging population in Transylvania County, it is imperative that the planning process for medical/facilities service seriously evaluates the needs of the current residents and forecast appropriately for the future increase in the elderly population. It is in the best interest of our residents and our community to provide as many health care services as possible on a local level, including dialysis services.

I humbly request your support in the petition for a local dialysis facility in Transylvania County.

Sincerely,

Scotta L. Orr

Scotta L. Orr, RN, BSN, MPH
Director, Quality/Accreditation Services
Transylvania Community Hospital

July 9, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

To Whom It May Concern,

I am writing this letter in support of a new dialysis center for Transylvania County. I work for Transylvania County in the transportation department as a van driver. I have been the driver for the dialysis van several times; thus I have seen first hand the tremendous toll that the day takes on the patients. In the morning they are tired at best, and then they have the long ride to Hendersonville with several stops along the way to pick up the other passengers. They arrive at the center for the treatment, which lasts up to 5 hours and physically drains them of what little energy they had before. Following this exhausting treatment, they have to endure the 1 to 1 ½ hour drive back home to Transylvania County. To see the drastic change in the clients from the morning to the evening will break your heart.

I urge you to please put yourself in this life saving situation, and please award Transylvania County the Certificate of Need for the dialysis center.

Sincerely,

D.D.

Delora Dennis
Van Driver
Transylvania County Transportation

Delora Dennis

July 7, 07

Medical Facility Planning Section
Division of Facility Services
Raleigh, N.C.

To whom it may concern

I am a former Transylvania County employee who drove the Med-Drive/Dialysis route for nearly five years. During that time I transported many dialysis patients who in addition to renal failure had a host of other related health problems such as diabetes, heart disease, stroke - impairment and paralysis. One patient who had to be transported in his wheelchair had a seizure on the way to the Hendersonville Center and had to be taken to the hospital. For another patient the trip to the center from his home was an hour and a half long. His treatment only lasted three and a half hours but he had to sit in the lobby for another two to three hours for the other patients who rode the van to finish their treatment. Then he had the one and a half hour trip back home to endure.

After a treatment, dialysis patients typically are very weak and they often can be nauseous to the point of vomiting as well and this was a normal occurance in the van. There were many occasions when I had to find a place to stop the van because a patient needed assistance.

A three to four and a half hour treatment became an all day ordeal for these folks and they had this to look forward to three times a week. A dialysis center in Transylvania County would make a tremendous difference for these extremely sick people. I support Mr. Smith in his effort to accomplish this.

Sincerely,
Margo McCall

My Grandmother [redacted]
goes to dialysis at a center in
Hendersonville the bus picks her up
at 9 am mama says grandma gets put
the Machine at 10:30 and gets off at
2:30 but grandma doesn't get
home till 4:30 or some time 5 pm
A center in Brevard would be a
blessing for my grandma.

Thankyou

Isaac Ashe

Letter for [redacted]

My Grandmother is a Dialysis patient We live in Brevard and she has her treatment in Hendersonville She rides a Van to and from, The van picks her up at 9:00 am. her treatment is 10:30 to 2:30 at the earliest she is home at 4:30 so she has to wait 2 hrs. after her treatment to get home. When she arrives she is in bad shape. She has to go straight to bed and is unable to get up. Also the van does not pick her up on holidays. So me with a toddler I find it hard to make Arrangements to take her and get her picked up. A Dialysis Center in Brevard would be a blessing. It would not be so hard on her Health and I know She would always have a way there and home.

Thank you
Rachel Hooper

Granny ([redacted])
goes to dialysis in Henderson. It
needs to go to a center Brevard

Thanks

Jacob Ashy

This Letter is for [redacted]

My Mother [redacted] is dialyzed three days a week in Henderson. We live in Brevard. Mom is picked up at 9 AM Taken to Hend. Dialysis for 4 hours 10:30 - 2:30 Mom does not get home till 4:30 or 5:00 pm She is hurting bad by the time she gets home She has to go to Hend. a dialysis Center in Brevard, Transylvania County would be convenient and so helpful to my Mom I believe it would help improve her quality of life if she did not have to wait so long to get home and then have to go to bed.

Thank you

Miriam Daniel

My mother, [redacted] has End Stage Renal Disease. She has been on dialysis for 10 years She lives in Brevard and travels to Hendersonville three days a week.

My mother has advanced Osteo-Arthritis in her back, both hips and knees. Both shoulders are affected by this, also.

Mom is picked up at 9:45 am by the van, Her transport is dialysis. She is usually on the machine by 10:30 am. She is displayed for four hours.

She is not always finished by 3:30 pm. She is home after her treatment 4:30 - 5:00 p.m. ok. Leaves home at 9 am and is gone until 4:30 or 5 pm. For 4 hours of treatment. Something is definitely wrong with this picture.

Mom is always in pain by the time she reaches home. She has to go straight to bed, often with pain medicine.

Her health and general life would be so much better if we had a

dialysis center in Brevard. We feel
for her to be gone from home 3 times
for a 4 hour treatment.
I am disabled and cannot drive
Mom to the Hendersonville Center.
A center in Brevard would truly be a
God send for my Mother.

Thank You.
Patricia Hopper

My Mother [redacted] has been a dialysis patient 4 about 10 years in Hendersonville. Momas Health would be a little more vital and Full maybe if she did not have to be gone 3 hours for a 4 hour treatment.

Rev. Billy Jarvis

Pastor. Mt Underwood Baptist Church

This letter is for [redacted]

My Grandmother is a dialysis patient. She goes to the Center in Hendersonville. She is gone for 3 hours for a 4 hour treatment. A Center in Brevard would be a God Send for my Grandmother.

Thank you

Rebecca Hooper

July 7, 2007

TO WHOM IT MAY CONCERN

Re: Letter of Support for Transylvania County - Petition to establish a local Dialysis Facility

The following points support our reason for this petition for a local dialysis facility in our county.

1. The well-being of the patient in being able to have dialysis treatment near home would make a big difference in many ways. The travel time, and many, many other benefits to patients and their family members.

2. We have in place local Doctors and staff to operate a dialysis facility and care for the patients.

3. In that we are in a area that so many people visit,or spend their vacation etc., having a dialysis facility would be beneficial to those visiting patients.

Signed: [signature] Date: 07-09-07

Note: Sister [redacted] Patient

July 7, 2007

TO WHOM IT MAY CONCERN

Re: Letter of Support for Transylvania County - Petition to establish a local Dialysis Facility

The following points support our reason for this petition for a local dialysis facility in our county.

1. The well-being of the patient in being able to have dialysis treatment near home would make a big difference in many ways. The travel time, and many, many other benefits to patients and their family members.

2. We have in place local Doctors and staff to operate a dialysis facility and care for the patients.

3. In that we are in a area that so many people visit,or spend their vacation etc., having a dialysis facility would be beneficial to those visiting patients.

Signed: Rebecca H Owen, Date: 7-8-07

Note: Friend of [redacted]

July 7, 2007

TO WHOM IT MAY CONCERN

Re: Letter of Support for Transylvania County - Petition to establish a local Dialysis Facility

The following points support our reason for this petition for a local dialysis facility in our county.

1. The well-being of the patient in being able to have dialysis treatment near home would make a big difference in many ways. The travel time, and many, many other benefits to patients and their family members.

2. We have in place local Doctors and staff to operate a dialysis facility and care for the patients.

3. In that we are in a area that so many people visit,or spend their vacation etc., having a dialysis facility would be beneficial to those visiting patients.

Signed: Barbara Hooper Date: 7-9-07

Note: Family Member [redacted]

I am a dialysis patient and i can't even begin to explain how grateful it would be to have a dialysis center in brevard.

You see i set for close to 3 to 5 hours maybe more and when i get on the bus all the fluid they removed from my weak body it makes me tired and sick so the 45 min to an hour ride back dosn't make it any easier.

When i get home i have no time left to spend with my lovely family or do what i would like to do.

A dialysis center here in brevard would be a convenice to i and others and cuts the time out from such a long ride

Thank you

I am a dialysis patient and i can't even begin to explain how grateful it would be to have a dialysis center in brevard

You see i set for close to 3 to 5 hours maybe more and when i get on the bus all the fluid they removed from my weak body it makes me tired and sick so the 45 min to an hour ride back dos nt make it any easier.

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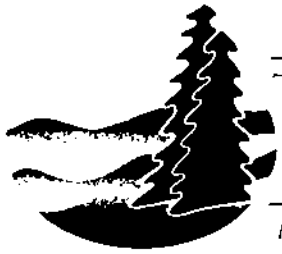
A dialysis center here in brevard would be a convenince to i and others and cuts the time out from such a long ride

Thank you



TRANSYLVANIA COMMUNITY HOSPITAL

Right Choice. Right Here.

June 28, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

RE: LETTER OF SUPPORT FOR TRANSYLVANIA COUNTY – PETITION TO ESTABLISH LOCAL DIALYSIS FACILITY

To The North Carolina State Health Coordinating Council:

On behalf of the community that we serve, the Board and Medical Staff of **Transylvania Community Hospital** strongly endorses and supports the petition for Transylvania County to qualify for Certificate of Need for an **End-Stage Renal Disease Dialysis Facility.** Transylvania County currently has 25 patients that are seeking dialysis outside of this community. This number has steadily increased from a low count of 19 in 2003. The county is experiencing a significant population boom, primarily of older retirees. Currently there are eleven new developments involving at least 3,171 dwelling units approved by our County Planning Board.

In addition the following points support our county's basis to position for a local dialysis treatment facility:

- 6 of the current 25 patients from Transylvania County are traveling more than 30 miles each way to a dialysis facility (30 miles is listed as the preferred maximum traveling distance for a dialysis patient). 1 patient travels more than 65 miles each way (a number of patients have to endure this commute three times a week).
- 16 of the current 25 patients from Transylvania County are traveling more than 40 minutes (each way) to a dialysis facility (a preferred maximum travel time is not listed in the State Medical Facility – we believe that approach fails to consider the unique geography of mountainous counties an associated travel challenges).
- Local nursing home facilities are not able to consider dialysis patients at this time due to the enormous burden of transporting patients to and out of county facilities – this separates families and creates barriers for other families that would like to relocate loved ones to local nursing homes. If there were such a facility, the population that requires a nursing home level of care, Transylvania County could easily meet the minimum requirements of 32 patients.
- Inclement (snow, ice, floods) in Transylvania County has created life threatening situations for our dialysis patients due to restricted travel.
- Transylvania County's patients have been served by facilities in Asheville and/or Hendersonville, and these facilities have used our county's demonstrated need to expand their facilities. From a geographical access perspective, there are portions of Henderson County such as Mills River, Horseshoe, Etowah and Crab Creek, where travel is easier to a Brevard location than it is to a location in Hendersonville and/or Asheville. Due to this consideration of that additional population and ease of access, this also supports our county's ability to easily meet the 32 patient requirement.

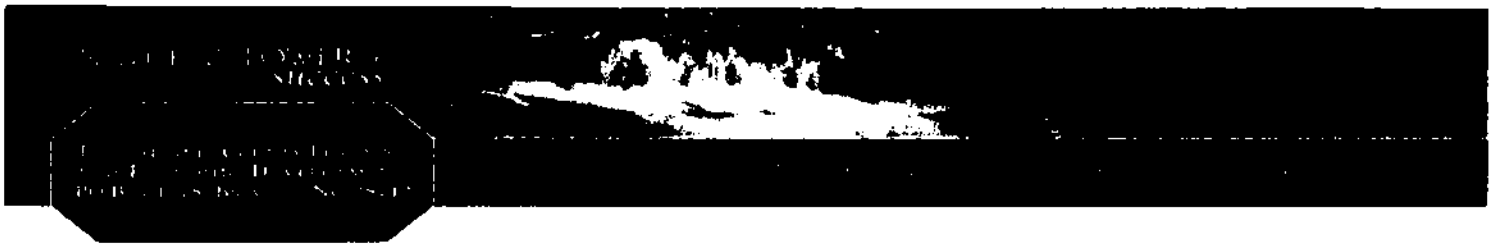
We thank you for your consideration of this and encourage you to include and establish the need for Transylvania County for an **End-Stage Renal Disease Dialysis Facility**.

Sincerely,

Robert J. Bednarek
President/CEO

Dana Christianson, MD
Chairman, Board of Trustee

Barry Bodie, MD
Chief of Staff



July 10, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

RE: LETTER OF SUPPORT
TRANSYLVANIA COUNTY – PETITION TO ESTABLISH LOCAL DIALYSIS FACILITY

To The North Carolina State Health Coordinating Council:

As the Planning and Economic Development Director for Transylvania County, I strongly support Transylvania County's petition to qualify for Certificate of Need for an **End-Stage Renal Disease Dialysis Facility.**

Transylvania County currently has 25 patients that require dialysis treatment, but must travel to another county to receive the care they require. As I understand, the number of patients has increased steadily over the last several years. Further, Transylvania County is experiencing a significant population growth, primarily of older retirees. The Planning Department and Planning Board have permitted or are aware of the potential for over 3,100 new dwelling units that may be built in the next five to six years. Some of these individuals will require dialysis treatment.

In addition the following points support our county's basis to position for a local dialysis treatment facility:

- 6 of the current 25 patients from Transylvania County are traveling more than 30 miles each way to a dialysis facility (30 miles is listed as the preferred maximum traveling distance for a dialysis patient). 1 patient travels more than 65 miles each way (a number of patients have to endure this commute three times a week).
- 16 of the current 25 patients from Transylvania County are traveling more than 40 minutes (each way) to a dialysis facility (a preferred maximum travel time is not listed in the State Medical Facility – we believe that approach fails to consider the unique geography of mountainous counties an associated travel challenges).
- Local nursing home facilities are not able to consider dialysis patients at this time due to the enormous burden of transporting patients to and from out of county facilities – this separates families and creates barriers for other families that would like to relocate loved ones to local nursing homes. If there were such a facility, the population that requires a nursing home level of care, Transylvania County could easily meet the minimum requirements of 32 patients.
- Transylvania County's patients have been served by facilities in Asheville and/or Hendersonville, and these facilities have used our county's demonstrated need to expand their facilities. From a geographical access perspective, there are portions of Henderson County such as Mills River, Horseshoe, Etowah and Crab Creek, where travel is easier to a Brevard location than it is to a location in Hendersonville and/or Asheville. Due to this consideration of that additional population and ease of access, this also supports our county's ability to easily meet the 32 patient requirement.

I encourage you to support Transylvania County's efforts to qualify for a Certificate of Need for an **End-Stage Renal Disease Dialysis Facility**.

Sincerely,

Mark R. Burrows, Director

phone 828.884.3205 *fax* 828.884.3275 *email* tcedc@citcom.net *website* http: econdev.transylvaniacounty.org

TRANSYLVANIA COMMUNITY HOSPITAL

Right Choice. Right Here.

DFS Health Planning
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JUL 11 2007

Medical Facilities Planning Section

June 28, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

RE: LETTER OF SUPPORT FOR TRANSYLVANIA COUNTY – PETITION TO ESTABLISH LOCAL DIALYSIS FACILITY

To The North Carolina State Health Coordinating Council:

On behalf of the community that we serve, the Board and Medical Staff of **Transylvania Community Hospital** strongly endorses and supports the petition for Transylvania County to qualify for Certificate of Need for an **End-Stage Renal Disease Dialysis Facility**. Transylvania County currently has 25 patients that are seeking dialysis outside of this community. This number has steadily increased from a low count of 19 in 2003. The county is experiencing a significant population boom, primarily of older retirees. Currently there are eleven new developments involving at least 3,171 dwelling units approved by our County Planning Board.

In addition the following points support our county's basis to position for a local dialysis treatment facility:

- 6 of the current 25 patients from Transylvania County are traveling more than 30 miles each way to a dialysis facility (30 miles is listed as the preferred maximum traveling distance for a dialysis patient). 1 patient travels more than 65 miles each way (a number of patients have to endure this commute three times a week).
- 16 of the current 25 patients from Transylvania County are traveling more than 40 minutes (each way) to a dialysis facility (a preferred maximum travel time is not listed in the State Medical Facility - we believe that approach fails to consider the unique geography of mountainous counties an associated travel challenges).
- Local nursing home facilities are not able to consider dialysis patients at this time due to the enormous burden of transporting patients to and out of county facilities -- this separates families and creates barriers for other families that would like to relocate loved ones to local nursing homes. If there were such a facility, the population that requires a nursing home level of care, Transylvania County could easily meet the minimum requirements of 32 patients.
- Inclement (snow, ice, floods) in Transylvania County has created life threatening situations for our dialysis patients due to restricted travel.
- Transylvania County's patients have been served by facilities in Asheville and/or Hendersonville, and these facilities have used our county's demonstrated need to expand their facilities. From a geographical access perspective, there are portions of Henderson County such as Mills River, Horseshoe, Etowah and Crab Creek, where travel is easier to a Brevard location than it is to a location in Hendersonville and/or Asheville. Due to this consideration of that additional population and ease of access, this also supports our county's ability to easily meet the 32 patient requirement.

We thank you for your consideration of this and encourage you to include and establish the need for Transylvania County for an **End-Stage Renal Disease Dialysis Facility**.

Sincerely,

Robert J. Bednarek
President/CEO

Dana Christianson, MD
Chairman , Board of Trustee

Barry Bodie, MD
Chief of Staff

North Carolina General Assembly
Senate

SENATOR JOHN J. SNOW, JR
50TH DISTRICT

OFFICE 2111 LEGISLATIVE BUILDING
16 W. JONES STREET
RALEIGH, NC 27601-2808

PHONE (919) 733-7875
(919) 754-3348 FAX

EMAIL johnsn@ncleg.net

DISTRICT 50TH

CHEROKEE JACKSON
CLAY MACON
GRAHAM SWAIN
HAYWOOD TRANSYLVANIA

COMMITTEES

CO CHAIR
APPROPRIATIONS ON JUSTICE AND PUBLIC SAFETY
MEMBER
AGRICULTURE/ENVIRONMENT/NATURAL RESOURCES
APPROPRIATIONS/BASE BUDGET
EDUCATION/PUBLIC INSTRUCTION
JUDICIARY II (CRIMINAL)
MENTAL HEALTH/YOUTH SERVICES
TRANSPORTATION
JOINT SELECT COMMITTEE ON EMERGENCY PREPAREDNESS AND DISASTER MANAGEMENT RECOVERY

July 11, 2007

DFS Health Planning
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JUL 13 2007
Medical Facilities
Planning Section

Dr. Dan Myers
Chairman
Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

RE: Transylvania County Dialysis Facility

Dear Dr. Myers,

I am writing you a letter in support of Transylvania County's petition for an End-State Renal Disease Dialysis Facility. In order to best help the citizens of North Carolina, I believe it is imperative that Transylvania County's petition should be approved. I further believe the stipulations placed upon Transylvania County go beyond reasonable.

As of the beginning of the year, only 78 of 149 certified facilities were operating at or above 80% utilization. I do not think it is fair to require Transylvania County to operate at a level of utilization that surpasses 48% of the certified facilities.

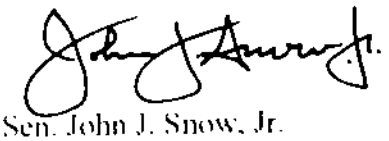
After looking at the figures, I have also noticed that many patients who would be served by this facility are traveling either close to or above an hour each way. This is an unfair burden on the rural at risk populations in North Carolina. As of April of this year, 24%

of the patients of the SE Kidney Council Inc. were traveling more than 30 miles for treatment with many traveling over an hour one way.

Likewise because of the areas vulnerability to extreme weather and terrain, many of these patients would be placed in a perilous situation in the event that travel is suspended for any period of time. If approved, this facility would reduce much of the life threatening ramifications the weather and terrain present. We must do more for the rural citizens of North Carolina.

Please support Transylvania County's petition for an End-State Renal Disease Dialysis Facility. I thank you for your time on this matter.

Sincerely,



Sen. John J. Snow, Jr.

Asheville PH
July 13, 2007
3 person comment

Transylvania County Petition for Adjustment to Need Determination
- Proposed 2008 State Medical Facilities Plan -

July 13, 2007
Public Hearing – Proposed 2008 State Medical Facilities Plan
Mountain Area Health Education Center (MAHEC)
501 Biltmore Avenue
Asheville, NC

DFS Health Planning
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JUL 13 2007

Medical Facilities
Planning Section

Comments from Transylvania County Delegation:

Mr. Steve Smith, Director – Transylvania County Department of Public Health
Mr. Robert J. Bednarek, President & CEO – Transylvania Community Hospital
Mr. Arthur C. Wilson, Jr., County Manager – Transylvania County

On behalf of Transylvania County, I'd like to thank the panel assembled here today for the opportunity to speak about our petition to adjust the current need determination for new dialysis stations. It's important that I acknowledge the presence of two gentlemen that have accompanied me today - Mr. Bednarek, President and CEO of Transylvania Community Hospital and Mr. Wilson, County Manager for Transylvania County. Their presence here today attests to the importance of this issue for our community.

Our petition (which we are prepared to submit today) outlines a comprehensive argument which identifies several inadequacies and inequities regarding the current need determination methodology and its application to Transylvania County. The petition includes a multitude of letters of support from past and current dialysis patients, community leaders and local government entities including the Town of Rosman, and Transylvania County. NC House of Representatives member Trudi Walend, NC Senator John Snow and United States House of Representatives member Heath Shuler have also endorsed our petition.

We are here today not because we believe we have a strong argument for establishment of a local dialysis facility. We're here today because we believe we have a definitive case. Accordingly, I'd like to outline several key components of our petition. I will also relate these key components to the basic principles underlying the projection of need for additional dialysis stations as specified in Chapter 14 of the *Proposed 2008 State Medical Facilities Plan*.

1. Basic principle: New facilities must have a projected need for at least 10 stations

The current need determination places an inordinate amount of focus on achieving a projected need of 10 dialysis stations. In order to achieve that level of need, jurisdictions must generate a projection of 32 in-center dialysis patients. We understand the cost efficiency basis for this threshold.

The validity of this standard, however, is brought into question if you consider that 48% (71 of 149) of the certified dialysis facilities in North Carolina are operating below the minimum 3.2 patients per station threshold (80% utilization rate). Requiring Transylvania County to achieve a projected need which exceeds the current utilization rate for approximately half of the state's existing facilities is not equitable.

2. Basic principle: End-stage renal disease treatment should be provided in North Carolina such that patients who require renal dialysis are able to be served in a facility no farther than 30 miles from the patient's home. (2 conflicts)

1st conflict
Based on an April 11, 2007 report from the Southeastern Kidney Council, Inc. (which defined 25 in-center patients as opposed to the 21 listed in the *July 2007 North Carolina Semiannual Dialysis Report*), 6 of 25 patients (24%) were traveling more than 30 miles to a facility. The mileage range for these 6 patients is 31.1 miles to 65.3. The average mileage for all 25 patients is 26.34 miles.

2nd conflict
Limiting the measure of access to a mileage basis is prejudicial toward western North Carolina counties because it fails to recognize unique travel challenges in mountainous regions. Our assertion is that 40 minutes of travel time should be a paired measure of access with travel distance. That assertion is based upon the belief that 30 miles of travel in the piedmont or coastal areas of the state would not typically take more than 40 minutes.

Based on the same Southeastern Kidney Council, Inc. report, 16 of 25 patients (64%) were traveling more than 40 minutes to a facility. The travel time range for these patients is 40 minutes to 107 minutes. The average travel time for all patients is 50.36 minutes.

In addition to these access challenges, severe weather conditions (snow, ice & flooding) in the mountains can create and have created life threatening situations for our local dialysis patients.

3. Basic principle: Services in rural, remote areas
NCGS 131E-175 (Certificate of Need Law)
(a concern that if left to the market place "...geographical maldistribution of these facilities and services would occur...")

According to your report, the *July 2007 North Carolina Semiannual Dialysis Report*, every county surrounding Transylvania County has a dialysis facility or facilities and the combined projected station surplus equals 36 stations for those counties. It defies logic that Transylvania County is surrounded by surplus stations and is being prevented from establishing its own dialysis facility.

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***

It is imperative that you understand the big picture here. If you don't remember another thing that was said here today remember this.....we maintain that there are sufficient dialysis treatment resources in the 5 county region just mentioned....Jackson, Haywood, Buncombe, Henderson and Transylvania. They are just in the wrong place. Establishing a dialysis facility in Transylvania County not only addresses our needs, it creates a more appropriate and more equitable distribution of dialysis treatment resources for the whole 5 county region. This petition is about what's best for everyone....not just Transylvania County and that ladies and gentlemen is what this whole process is supposed to be about.

Thank you for your consideration of our petition. We trust you will find that our compelling case of need warrants an adjustment to the need determination for a dialysis facility in Transylvania County so that we may proceed with a Certificate of Need application in the immediate future.

I would now like to yield any remaining time we may have to Mr. Bednarek or Mr. Wilson if they'd like to make any closing remarks.

HEATH SHULER
11TH DISTRICT, NORTH CAROLINA

[illegible]
Washington, DC 20515
Phone: 202-225-6401
Fax: 202-226-1422

[illegible]
Asheville, NC 28801
Phone: 828-252-1651
Fax: 828-252-8734

Congress of the United States
House of Representatives
Washington, DC 20515–3311

DEPUTY AT LARGE WHIP

COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE
[illegible]

COMMITTEE ON NATURAL RESOURCES
[illegible]

COMMITTEE ON SMALL BUSINESS
[illegible]
CHAIRMAN

DFS Health Planning
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[illegible]
Medical Facilities
Planning Section

July 12, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

To Whom It May Concern:

I am writing to express my support for Transylvania County's petition to establish a local dialysis facility.

The petition cites a number of compelling reasons why a new facility is needed in the county. Of the county's 25 current dialysis patients, many are required to travel over 30 miles and one patient over 65 miles each way, three times per week. This creates a significant burden of time and cost for these patients and their families. The mountainous terrain and associated inclement weather can also limit a patient's ability to travel and obtain necessary treatment.

Perhaps most importantly, the county's local nursing home facilities are unable to accept dialysis patients because of the lack of a local facility. Families are therefore forced to relocate loved ones to nursing homes far from home and closer to dialysis facilities. A local facility would greatly reduce these various risks and burdens, while reflecting a higher and more accurate number of Transylvania patients in need of such a facility.

I ask that you give this petition your most thoughtful and serious consideration. If you need additional information, please contact Tom Jones in my district office at 828-252-1651 extension 15.

Thank you very much for your time and attention to this matter. Please do not hesitate to contact me if I may be of assistance as you make your determinations.

Sincerely,

Heath Shuler
Member of Congress
11th District, North Carolina

Asheville PH
July 13, 2007
ESP

COUNTY MANAGER
Arthur C. Wilson, Jr.
828-884-3100
Fax 828-884-3119
828-884-3177
33 East Main Street
Brevard, NC 28712

Transylvania County

June 27, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Ref: Letter of Support for Transylvania County-Petition to establish Local Dialysis Facility

Dear Sirs:

As Chairman of the Board of Commissioners of Transylvania County I hereby request that you consider allowing a local dialysis treatment facility to be located in Transylvania County. Currently six of the twenty five patients from Transylvania County are traveling more than thirty miles each way to a dialysis facility. Thirty miles is listed as the preferred maximum traveling distance for dialysis patients in the State Medical Facilities Plan. One patient travels more than sixty fives miles each way. These trips are made by these patients three times a week. Sixteen of the twenty five patients from Transylvania County are traveling more than forty minutes each way to a dialysis facility. Considering the geography of our county where one can go from a level of 2,350 feet to a height of 6,000 feet presents serious challenges to our residents to get to the nearest dialysis facility in an adequate time frame especially during inclement weather such as snow, ice and floods.

Local nursing home facilities are not able to consider dialysis patients at this time due to the enormous burden of transporting patients to out of county facilities. This separates families and creates barriers for other families that want to relocate loved ones to local nursing homes. As of June 30, 2006, only 52% of certified facilities in North Carolina were operating at or above 80% utilization. This means that 48% of the certified facilities operating in NC are functioning below the level required of us to establish a new dialysis facility in our county.

Transylvania County continues to be rated as one of the hot spots for retirement in the United States. With an aging community we need to have a dialysis facility located in our county.

Sincerely,

Jason R. Chappell, Chairman
Board of County Commissioners

acw

Cc: Members, Board of Commissioners
County Manager
Health Director
File

COUNTY MANAGER
Arthur C. Wilson, Jr.
828-884-3[illegible]
Fax 828-884-3179
828-884-3[illegible]
21 East Main Street
Brevard, NC 28712

Transylvania County

June 29, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Ref: Letter of Support for Transylvania County-Petition to establish Local Dialysis Facility

Dear Sirs:

As the County Manager of Transylvania County I hereby request that you consider allowing a local dialysis treatment facility to be located in Transylvania County. Currently six of the twenty five patients from Transylvania County are traveling more than thirty miles each way to a dialysis facility. Thirty miles is listed as the preferred maximum traveling distance for dialysis patients in the State Medical Facilities Plan. One patient travels more than sixty fives miles each way. These trips are made by these patients three times a week. Sixteen of the twenty five patients from Transylvania County are traveling more than forty minutes each way to a dialysis facility, that is, if it is a good weather day. Being located in the mountains presents problems with snow, ice, and floods since we are on the headwaters of the French Broad River.

Local nursing home facilities are not able to consider dialysis patients at this time due to the enormous burden of transporting patients to out of county facilities. This separates families and creates barriers for other families that want to relocate loved ones to local nursing homes. As of June 30, 2006, only 52% of certified facilities in North Carolina were operating at or above 80% utilization. This means that 48% of the certified facilities operating in NC are functioning below the level required of us to establish a new dialysis facility in our county.

Transylvania County continues to be rated as one of the best locations for retirement in the United States. With an aging community we need to have a dialysis facility located in our county.

Sincerely,

Arthur C. Wilson, Jr.
County Manager

Cc: Health Director

Fresenius Medical Care

September 4, 2007

State Medical Facilities Planning Section
Attn: Ms. Victoria McClanahan
Division of Health Service Regulation
North Carolina Department of Human Resources
701 Barbour Drive
Raleigh, NC 27603

Re: Transylvania County Petition for Adjustment to Need Determination, Proposed 2008 State Medical Facilities Plan

Dear Ms. McClanahan:

Fresenius Medical Care, d/b/a Bio-Medical Applications of North Carolina eagerly supports the above noted petition for an adjusted need determination to establish an end-stage renal disease dialysis facility in Transylvania County. The petitioner clearly identifies one of the primary issues for dialysis patients across the state:

> "Extreme travel distances, extreme travel times, segregation of families and the associated hardships placed on patients and their families highlight a dire situation."

There is precedence for an adjusted need determination:

The State Health Coordinating Council has responded favorably to such petitions in the recent past. For example, consider the following:

a. The SHCC established an adjusted need for McDowell County in the 2004 State Medical Facilities Health Plan, allowing for development of a nine station dialysis facility.
b. The SHCC established an adjusted need determination for the combined Cherokee, Clay and Graham County service area in the 2005 SMFP. This allowed development of a 10 station dialysis facility.
c. The SHCC again established an adjusted need determination for the combined Avery, Mitchell, and Yancey County service area in the 2006 SMFP. This allowed development of a nine stations dialysis facility.

3867 Dunn Road
Fayetteville, NC 28312
Phone: 910-433-2053 FAX: 910-323-4942

BMA urges the SHCC to consider approval of this petition, and approve an adjusted need determination for an eight (8) station dialysis facility in Transylvania Count. BMA offers the following discussion to support the need for an eight station facility.

The Transylvania County ESRD population will continue to increase:

The July 2007 Semiannual Dialysis Report indicates that the Transylvania Five Year Average Annual Change Rate for the dialysis population is 3.0%. If the growth materializes as the SDR projects, (24.7 patients) for December 31, 2007, that Five Year Average Annual Change Rate would more than double to 7.1%. The following calculations will demonstrate this change.

Census Date	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	Projected, 12/31/2007
Census	22	19	22	21	24	24.7
Raw Change		-3	3	-1	3	0.7
% Change		-13.64%	15.79%	-4.55%	14.29%	2.92%
Five Year Average Annual Change					2.97%	7.11%

In as much as patients are not fractional numbers, BMA has evaluated the growth by rounding the projected census for December 31, 2007 both up the next whole number, 25, and by rounding down to 24.

Consider the effects of rounding up to 25 projected patients at December 31, 2007:

Census Date	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	Projected, 12/31/2007
Census	22	19	22	21	24	25
Raw Change		-3	3	-1	3	1
% Change		-13.64%	15.79%	-4.55%	14.29%	4.17%
Five Year Average Annual Change					2.97%	7.42%

In this case the growth climbs to a Five Year Average Annual Change Rate of 7.42%

Alternatively, in a worst case scenario, consider the growth if the projected census for December 31, 2007 were rounded down to 24 patients:

Census Date	12/31/2002	12/31/2003	12/31/2004	12/31/2005	12/31/2006	Projected, 12/31/2007
Census	22	19	22	21	24	24
Raw Change		-3	3	-1	3	0
% Change		-13.64%	15.79%	-4.55%	14.29%	0.00%
Five Year Average Annual Change					2.97%	6.38%

The significance here is that with a demonstrated zero growth year 2006 over year 2005, the Five Year Average Annual Change Rate will double the current rate of 3.0% as published within the July 2007 SDR

BMA recommends an Adjusted Need Determination for an Eight Station Dialysis Facility:

BMA recommends that the SHCC approve this petition and establish an adjusted need determination for an eight station dialysis facility in Transylvania County. The growing population of this county warrants an eight station dialysis facility.

- Practically speaking, if the SHCC approves this petition, the adjusted need would likely be published in the 2008 SMFP and the January 2008 SDR.
- Presumably Certificate of Need Applications would be filed March 15, 2008.
- Based upon recent CON applications in a competitive review, the CON Agency will conduct a Public Hearing, and establish a 150 day review period for the applications which may be received.
- Following the decision, and assuming no appeal is filed by an aggrieved party, the Certificate of Need would be issued no less than 30 days following the decision date.
- Thus, the actual certificate is not likely to be issued until early October 2008.
- Assuming an aggressive development for a facility, with minimal weather delays, it is reasonable to conclude that a new dialysis facility could conceivably open by June 30, 2009.
- Throughout this time, 21 months from the date of this letter, the ESRD population of Transylvania continues to grow at the published Five Year Average Annual Change Rate, 3.0%. As the next table demonstrates, the census on June 30, 2009 is likely to be 25.8 patients, rounded to 26 patients.

Census Date	12/31/2006	12/31/2007	12/31/2008	6/30/2009
Transylvania ESRD Population	24	24.7	25.5	25.8

The CON agency generally calculates station utilization based a utilization ratio of 3.2 patients per station. A patient population of 25 dialysis patients would then require 7.8, or 8 dialysis stations.

Each dialysis station can typically provide treatment to four dialysis patients per week, (two shifts per day, morning and afternoon, using two three-day shift schedules, Monday – Wednesday-Friday, or Tuesday-Thursday-Saturday); as a result, eight dialysis stations could reasonably serve 32 dialysis patients. Thus, an eight station facility does allow for continued growth of the dialysis population.

Summary:

BMA is clearly aware of the need to bring dialysis as close to the patient residence as possible. The dialysis patient population of Transylvania County has a need for an eight station dialysis facility. BMA strongly supports the petitioner and urges the SHCC to adopt this adjusted need determination for the 2008 SMFP.

If you have any questions, or I can be of further assistance, please contact me at 910-433-2053.

Sincerely,

Jim Swann
Regional Director of Health Planning

Cc: Steven E. Smith, Director – Transylvania County Department of Public Health

Recommendations and Related Materials

Behavioral Health Chapters

For the

LONG-TERM AND BEHAVIORAL HEALTH COMMITTEE MEETING

On

September 14, 2007

Agency Recommendations related to Behavioral Health issues

for the

Long-Term and Behavioral Health Committee

September 14, 2007

Agency recommendations regarding the Final 2008 State Medical Facilities Plan (SMFP) for consideration by the North Carolina State Health Coordinating Council are as follows:

Issues Related to Psychiatric Inpatient Services
The Agency recommends adoption of the final Chapter by the SHCC with any appropriate updates in the narrative and with continued updated inventory or other appropriate data in the Chapter's tables.

The Agency recommends that Policy PSY-2 be strengthened by changing a portion of the language that was in the Proposed 2008 SMFP. There were no comments or petitions submitted during the public review and comment period related to Policy PSY-2.

There is one petition and two comments for consideration, and they are attached.

One petition is from Appalachian Regional Healthcare System, Boone, N.C. requesting that the State Health Coordinating Council (SHCC) approve an adjustment to the need determination for 10 adult psychiatric beds to be included in Chapter 15 of the Final 2008 State Medical Facilities Plan (SMFP). The Agency recommends the adjusted need determination, and **the need determination would be for 10 adult inpatient psychiatric beds in Mental Health Planning Area 3 to be included in Chapter 15 of the Final 2008 State Medical Facilities Plan.**

The comments are from T.W. McDevitt, CEO of Smoky Mountain Center, Boone N.C., and Robert J. Wilson, Avery County Director, New River Behavioral HealthCare, Newland, N.C. The comments are supportive of the petition from Appalachian Regional Healthcare System.

Issues Related to Substance Abuse Inpatient and Residential Services
The Agency recommends adoption of the final Chapter by the SHCC with any appropriate updates in the narrative and with continued updated inventory or other appropriate data in the Chapter's tables. There was one petition and no comments received during the public review and comment period, and it is attached.

The petition is from Path of Hope, Inc., Lexington, N.C. requesting that the State Health Coordinating Council (SHCC) approve an adjustment to the need determination for twelve (12) adult chemical dependency (substance abuse) residential treatment beds for the Piedmont

Behavioral Healthcare Planning Area, comprising of Cabarrus, Davidson, Rowan, Stanly and Union Counties to be included in the Final 2008 State Medical Facilities Plan (SMFP). The Agency recommends the adjusted need determination, and the **need determination would be for 12 adult chemical dependency (substance abuse) residential treatment beds for the Piedmont Behavioral Healthcare Mental Health Planning Area to be included in Chapter 16 of the Final 2008 State Medical Facilities Plan.**

Issues Related to Intermediate Care Facilities for the Mentally Retarded
There were no petitions and one comment received during the public review and comment period, and it is attached.

The comment is from Elizabeth Huesemann, Executive Director of the Irene Wortham Center, Asheville, N.C.

The Agency recommends adoption of the final Chapter by the SHCC with any appropriate updates in the narrative and with continued updated inventory or other appropriate data in the Chapter's tables.

(BHAgencyrec2008f.doc 9/6/2007

LT/BH COMMITTEE

❖❖❖

Material Related To

Psychiatric Inpatient Services
For the Final 2008 SMFP

September 14, 2007

Policy PSY-2

Agency Analysis related to Petition from
Appalachian Regional Healthcare System

Petition:
Appalachian Regional Healthcare System

Comments:
Smoky Mountain Center
New River Behavioral HealthCare

POLICY MH-1: LINKAGES BETWEEN TREATMENT SETTINGS

An applicant for a certificate of need for psychiatric, substance abuse, or Intermediate Care Facilities for the Mentally Retarded (ICF/MR) beds shall document that the affected Local Management Entity has been contacted and invited to comment on the proposed services.

POLICIES APPLICABLE TO PSYCHIATRIC INPATIENT SERVICES FACILITIES (PSY)

POLICY PSY-1: TRANSFER OF BEDS FROM STATE PSYCHIATRIC HOSPITALS TO COMMUNITY FACILITIES

Beds in the State psychiatric hospitals used to serve short-term psychiatric patients may be relocated to community facilities through the Certificate of Need process. However, before beds are transferred out of the State psychiatric hospitals, services and programs shall be available in the community. State hospital beds that are relocated to community facilities shall be closed within ninety days following the date the transferred beds become operational in the community.

Facilities proposing to operate transferred beds shall submit an application to the Certificate of Need Section of the Department of Health and Human Services and commit to serve the type of short-term patients normally placed at the State psychiatric hospitals. To help ensure that relocated beds will serve those persons who would have been served by the State psychiatric hospitals, a proposal to transfer beds from a State hospital shall include a written memorandum of agreement between the Local Management Entity serving the county where the beds are to be located, the Secretary of Health and Human Services, and the person submitting the proposal.

POLICY PSY-2: ALLOCATION OF PSYCHIATRIC BEDS

A hospital submitting a Certificate of Need application to add inpatient psychiatric beds shall convert excess licensed acute care beds to psychiatric beds. In determining excess licensed acute care beds, the hospital shall subtract the average occupancy rate for its licensed acute care beds (adjusted for any CON-approved deletions) over the previous 12-month period from the appropriate target occupancy rate of acute care beds listed in Policy AC-4 and multiply the percentage difference by the number of its existing licensed acute care beds**, then subtract from the result the number of** ~~and the~~ approved ~~non-operational~~ **new** acute care beds **which are pending development**.

POLICIES APPLICABLE TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)

LONG-TERM and BEHAVIORAL HEALTH COMMITTEE
Petition from
Appalachian Regional Healthcare System
In regards to
Psychiatric Inpatient Services – Chapter 15
Regarding the Proposed 2008 SMFP
For the Final 2008 SMFP

AGENCY ANALYSIS:
LTBHC Petition: Appalachian Regional Healthcare System
Boone, Watauga County, North Carolina

Request

The Petitioner requests that the State Health Coordinating Council (SHCC) approve an adjusted need determination for ten (10) adult inpatient psychiatric beds to be included in Chapter 15 of the Final 2008 State Medical Facilities Plan (SMFP).

Background Information

Over the last several years, there have been mental health program reform efforts. One of the reforms has been the consolidation of mental health planning area programs or Local Management Entities (LMEs). Previously, there were 30 area entities. As of July 1, 2007, the total number of LMEs has been reduced to 25 area entities.

The steps in the methodology in the Proposed 2008 SMFP for Psychiatric Inpatient Services was applied individually to the then 30 mental health planning area programs, and then bed surpluses/deficits in the areas were combined to arrive at the total surpluses/deficits for the four designated mental health planning regions. A mental health planning region must have a bed deficit of 10 beds or greater to result in a need determination for child/adolescent or adult psychiatric inpatient beds. A bed deficit of less than ten beds does not result in a determination of need.

Analysis/Implications

The Petitioner states that a deficit of 17 adult inpatient psychiatric beds is identified in the Proposed 2008 SMFP for Mental Health Planning Area 3, which is in the Western Mental Health Planning Region. Mental Health Planning Area 3 is comprised of Alleghany, Ashe, Avery, Watauga and Wilkes counties. The petitioner continues that this deficit is suppressed by excess adult inpatient psychiatric beds in several counties in the 34-county Western Mental Health Planning Region.

The petitioner requests that the need for Mental Health Planning Area 3 be separated from the regional planning total, and there be an adjusted need determination for ten (10) adult inpatient psychiatric beds to be included in Chapter 15 of the Final 2008 SMFP. The petitioner notes that Cannon Memorial Hospital did have 20 adult inpatient psychiatric beds in Mental Health Planning Area 3 prior to asking that the beds be de-licensed.

The petitioner indicates that Cannon Memorial's decision was based on an erroneous interpretation of federal law regarding the operation of more than 25 beds by a federally designated critical access hospital. Appalachian Regional Healthcare System, the petitioner, is the parent company of Cannon Memorial

The SHCC and the Division of Health Service Regulation have been supportive of adjusted need determinations in the mental health areas, if a petitioner has demonstrated a willingness to provide a needed service. If an acute care hospital is willing to provide psychiatric services for a community, the Agency has generally been supportive.

Agency Recommendation

The Agency recommends approval of an adjusted need determination for 10 adult inpatient psychiatric beds in Mental Health Planning Area 3 to be included in Chapter 15 of the Final 2008 State Medical Facilities Plan.

APPALACHIAN
Regional Healthcare System
Watauga Medical Center • Cannon Memorial Hospital

Petition to State Health Coordinating Council

Adjustment to Psychiatric Bed Need Included in the Proposed 2008 State Medical Facilities Plan

July 13, 2007

Petitioner: Appalachian Regional Healthcare System
336 Deerfield Road
Boone, NC 28607

Contact: Tim Ford, Senior Vice President
Appalachian Regional Healthcare System
336 Deerfield Road
Boone, NC 28607
(828) 262-4100

Statement of Requested Change

Petition

Appalachian Regional Healthcare System is submitting this petition to the State Health Coordinating Council requesting an adjustment to the need determination for adult psychiatric beds included in Chapter 15 of the Proposed 2008 State Medical Facilities Plan.

A deficit of 17 adult psychiatric beds is identified on page 304 in the Proposed 2008 State Medical Facilities Plan for Mental Health Planning Area 3, which includes Alleghany, Ashe, Avery, Watauga, and Wilkes Counties. This deficit however is suppressed by excess adult psychiatric beds in several other counties in the 34-county Western Mental Health Planning Region. Appalachian Regional Healthcare System is specifically requesting that the need for psychiatric beds in Mental Health Planning Area 3 be separated from the regional planning total, for one planning year, and an adjusted need determination for 10 inpatient adult psychiatric beds identified in the 2008 State Medical Facilities Plan.

Proposed Adult Psychiatric Bed Need Adjustment Data and Information

The following table highlights the adult psychiatric inpatient services in the 34-county Western Mental Health Planning Region. The table presents the number of licensed adult psychiatric beds identified in Table 15A on page 301 of the Proposed 2008 State Medical Facilities Plan; the number of FY2006 adult inpatient psychiatric days of care; the projected number of FY2010 adult inpatient psychiatric days of care; and the associated adult psychiatric bed surplus or deficit.

Inpatient Psychiatric Service	County	Licensed Psychiatric Beds	Actual FY2006 Days of Care	Projected FY2010 Days of Care	Bed Need (+ Surplus/ - Deficit)
Area 1					
Total for Area 1		**0**	**3,589**	**3,761**	**- 14**
Area 2					
Mission-St. Joseph's Health System	Buncombe	48			
Pardee Memorial Hospital	Henderson	21			
Park Ridge Hospital	Henderson	41			
Rutherford Hospital	Rutherford	14			
St. Luke's Hospital	Polk	10			
Total for Area 2		**134**	**15,287**	**16,034**	**+ 75**
Area 3					
Total for Area 3		**0**	**4,481**	**4,585**	**- 17**
Area 4					
Grace Hospital	Burke	22			
Total for Area 4		**22**	**4,869**	**9,258**	**- 12**
Area 5					
King's Mountain Hospital	Cleveland	14			
Gaston Memorial Hospital	Gaston	43			
Total for Area 5		**57**	**14,513**	**15,081**	**+ 2**
Area 6					
Frye Regional Medical Center	Catawba	56			
Catawba Memorial	Catawba	28			
Total for Area 6		**84**	**6,301**	**6,631**	**+ 60**
Area 7					
Presbyterian Hospital	Mecklenburg	40			
Carolinas Medical Center	Mecklenburg	44			
Total for Area 7		**84**	**18,714**	**20,711**	**+ 8**
Area 8					
Stanly Memorial Hospital	Stanly	12			
Northeast Medical Center	Cabarrus	10			
Rowan Memorial Hospital	Rowan	15			
Thomasville Medical Center	Davidson	26			
Total for Area 8		**63**	**13,955**	**15,058**	**+ 8**
Total for South Central Region		**444**	**85,817**	**91,111**	**+ 110**

In FY2005, Cannon Memorial Hospital's adult psychiatric inpatient unit provided 3,829 days of care. In December 2005, Cannon Memorial Hospital notified the North Carolina Licensure and Certification Branch that Cannon Memorial Hospital would be de-licensing its 20 adult psychiatric beds. In January 2006, Cannon Memorial Hospital terminated its psychiatric unit participation in the Medicare and Medicaid Programs. This decision was based an erroneous interpretation of federal law regarding the operation of more than 25 beds by a federally-designated, critical access hospital. Cannon Memorial Hospital became a federally-designated critical access hospital on December 31, 2005. This designation limits the number of beds the facility can operate to 25 beds.

However, after the de-licensing of the 20 adult psychiatric beds and resulting termination of its Medicare and Medicaid participation, it was determined that Cannon Memorial Hospital could actually operate a separate psychiatric unit, with up to 10 beds, without risking its federal designation as a critical access hospital.

Further complicating this issue for residents of the North Carolina High Country is the closing and reduction of state-controlled psychiatric hospitals and the need to locate inpatient psychiatric care to local communities.

Appalachian Regional Healthcare System requests that the State Health Coordinating Council adjust the adult psychiatric bed need determination for Mental Health Service Area 3 to reflect a need determination of 10 adult psychiatric beds.

Support

Appalachian Regional Healthcare System, the parent company of Cannon Memorial Hospital, has ongoing referral relationships with most hospitals within the 5-county inpatient psychiatric service area, as well as area mental health communities. Appalachian Regional Healthcare System has also met with representatives of the North Carolina Division of Facility Services and has received support for adjusting the adult psychiatric bed need determination for Mental Health Service Area 3.

Summary

Appalachian Regional Healthcare System is requesting that the 17-bed adult psychiatric inpatient bed deficit in Mental Health Service Area 3 identified in the Proposed 2008 State Medical Facilities Plan be separated from the regional planning total and a need determination for 10 adult psychiatric beds for Mental Health Service Area 3 be identified in the 2008 State Medical Facilities Plan.

Smoky Mountain Center
895 State Farm Road
Suite 404
Boone, NC 28607

SMOKY MOUNTAIN CENTER

"Meeting community needs... one person at a time."

Northern Regional
Administrative Office
828-263-5635
www.smokymountaincenter.org

July 31, 2007

Dr. Dan A. Myers, Chairman
State Health Coordinating Council
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Dear Dr. Myers:

I am writing this letter in support of the Petition to the State Health Coordinating Council by Appalachian Regional Healthcare System (ARHS). I understand that ARHS is submitting a petition to the State requesting an adjustment to the need determination for adult psychiatric beds included in Chapter 15 of the Proposed 2008 State Medical Facilities Plan. It is also our understanding that a deficit of inpatient psychiatric beds exists in Mental Health Planning Region 3. Alleghany, Ashe, Avery and Watauga counties are areas that are also covered by our agency.

Smoky Mountain Center LME is committed to serving individuals in their home communities and welcomes the opportunity to work with Appalachian Regional Healthcare System.

Sincerely,

T.W. McDevitt

T.W. McDevitt, CEO
Smoky Mountain Center LME

NEW RIVER BEHAVIORAL HEALTHCARE

July 31, 2007

Dr. Dan A. Myers, Chairman
State Health Coordinating Council
Division of Facility Services
2714 Mail Service Center
Raleigh, NC 27699-2714

Dear Dr. Myers:

I am writing this letter in support of the Petition to the State Health Coordinating Council by Appalachian Regional Healthcare System (ARHS). I understand that ARHS is submitting a petition to the State requesting an adjustment to the need determination for adult psychiatric beds included in Chapter 15 of the Proposed 2008 State Medical Facilities Plan. It is also our understanding that a deficit of inpatient psychiatric beds exists in Mental Health Planning Region 3. Alleghany, Ashe, Avery and Watauga counties are areas that are also covered by our agency.

New River Behavioral Health Care is a five-county outpatient service provider that utilized the psychiatric facility at Cannon Memorial Hospital prior to their closing in December 2005. Watauga and Avery Counties primarily utilized this facility for the treatment of our existing clients and those non-clients that were seen for emergency crisis services. Since the facility has closed the nearest hospitals for treatment are in Hickory, Morganton, Asheville, Charlotte or Winston-Salem. The distance to travel to these hospitals creates a hardship for family members and law enforcement involved transportation. Inpatient treatment for the mentally ill for the citizens of our community would be greater enhanced if it was available at Cannon Hospital.

Sincerely,

Robert J. Wilson MA, LPC, MBA
Avery County Director

LT/BH COMMITTEE

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Material Related To

Substance Abuse Inpatient and Residential Services
For the Final 2008 SMFP

September 14, 2007

Agency Analysis related to Petition from
Path of Hope, Inc.

Petition:
Path of Hope, Inc.

LONG-TERM and BEHAVIORAL HEALTH COMMITTEE
Petition from
Path of Hope, Inc.
In regards to
Substance Abuse Inpatient and Residential Services – Chapter 16
Regarding the Proposed 2008 SMFP
For the Final 2008 SMFP

AGENCY ANALYSIS:
LTBHC Petition: Path of Hope, Inc.
Lexington, Davidson County, North Carolina

Request

The Petitioner requests an adjusted need determination for twelve (12) additional adult chemical dependency (substance abuse) residential treatment beds.

Background Information

Over the last several years, there have been mental health program reform efforts. One of the reforms has been the consolidation of mental health planning area programs or Local Management Entities (LMEs). Previously, there were 30 area entities. As of July 1, 2007, the total number of LMEs has been reduced to 25 area entities.

Piedmont Behavioral Healthcare Mental Health Planning Area is comprised of Cabarrus, Davidson, Rowan, Stanly and Union Counties.

The steps in the methodology in the Proposed 2008 SMFP for Substance Abuse Inpatient and Residential Services was applied individually to the then 30 mental health planning area programs, and then bed surpluses/deficits in the areas were combined to arrive at the total surpluses/deficits for the four designated mental health planning regions.

Any bed need determination shall be designated as a residential treatment bed need determination. Any residential treatment bed need determination not applied for would be reallocated in accordance with Policy GEN-1 and designated for either a residential or a hospital-based treatment bed need determination.

Analysis/Implications

The petitioner states that Path of Hope, Inc. contracts with three LMEs: Piedmont Behavioral Healthcare, Sandhills, and Alamance-Caswell-Rockingham. It also contracts with several CJP programs and have been asked to submit a proposal with the Federal Probation Department.

The petitioner continues that the three LMEs that it serves have a population total of over 1,417,000. The waiting list at Path of Hope, Inc. for men it is currently four weeks and for women it is currently eight weeks. The petitioner indicates that it had approximately a 97% occupancy rate for the calendar year 2006-2007.

The petitioner is interested in adding six (6) adult female chemical dependency (substance abuse) residential treatment beds and six (6) adult male chemical dependency (substance abuse) residential treatment beds.

The SHCC and the Division of Health Service Regulation have been supportive of adjusted need determinations in the mental health areas, if a petitioner has demonstrated a willingness to provide a needed service.

In discussions with the Agency, the petitioner indicates that it is asking for an adjusted need determination for twelve (12) substance abuse treatment beds for the Piedmont Behavioral Healthcare Mental Health Planning Area. The adjusted need determination has to be for twelve adult chemical dependency (substance abuse) residential treatment beds. The designation for the need determination could not be for six (6) adult female chemical dependency (substance abuse) residential treatment beds and six (6) adult male chemical dependency (substance abuse) residential treatment beds. If there was an adjusted need determination, it would be for the Piedmont Behavioral Healthcare Mental Health Planning Area and any interested facility or other applicant in that planning area could apply for the Certificate of Need.

Agency Recommendation

The agency recommends approval of an adjusted need determination for 12 adult chemical dependency (substance abuse) residential treatment beds for the Piedmont Behavioral Healthcare Mental Health Planning Area to be included in Chapter 16 of the Final 2008 State Medical Facilities Plan.

Path Of Hope, Inc

P. O. Box 1824
Lexington, NC. 27293-1824
Office-336-248-8914//Fax-336-248-2138//Email pathofhope@lexcominc.net

PETITION

August 3, 2007

Medical Facilities Planning Section
Division of Facility Services
2714 Mail Service Center
Raleigh, NC, 27699-2714

To Whom It May Concern:

Path of Hope, Inc. would like to petition for twelve additional substance abuse residential treatment beds. We are currently licensed under two different facilities code licenses – MHL-029-006 and MHL-029-007. We hold certificates for twelve male and six female SA residential treatment beds.

Path of Hope, Inc.
1675 East Center Street Ext.
Lexington, NC, 27292

Path of Hope, Inc. contracts with three LMEs: Piedmont Behavioral Healthcare, Sandhills, and Alamance-Caswell-Rockingham. We also contract with several CJP programs and have been asked to submit a proposal with the Federal Probation Department. The waiting list for men is currently four weeks and for women is currently eight weeks.

According to statistics from the 2007 SMFP, the three LMEs that we serve have a population total of over 1,417,000. There are a total of 50 substance abuse residential treatment beds in those three areas. Of those, 20 are at a private-for-profit, 24 are for males at non-profits, and 6 are for females at a non-profit. Although the report states that there are no more adult beds needed, the waiting list at Path of Hope, Inc. for men is currently four weeks and for women is currently eight weeks. We had approximately a 97% occupancy rate for the calendar year 2006-2007.

Due to the wait time associated with substance abuse residential treatment bed availability, many residents are being sent home from detox centers in all three areas. Thus, they are not receiving seamless care in the SA continuum of care. The majority of

Path Of Hope, Inc

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Office-336-248-8914//Fax-336-248-2138//Email pathofhope@lexcominc.net

residents who are in detox meet ASAM criteria for SA residential treatment. There are not adequate Intensive Outpatient Programs or Comprehensive Outpatient Treatment Programs available and even when there is, transportation, housing, and social supports are often not available to support residents being successful in outpatient.

Sandhills LME has supported Path of Hope, Inc. in securing a mental health trust fund grant which we plan to use to serve female substance abuse residents. Oakwood Homes and Sandhills LME are partnering with Path of Hope, Inc. to build a new facility that will originally house six residents (our current CON) but will have the capacity to house twelve residents.

Everywhere I travel across the state and particularly when I am in Raleigh, I hear how it is impossible to place women without children in substance abuse residential treatment. I have also been involved in the NC SA Federation meetings, various conferences across the state, and other meetings where it has been noted that SA admissions are down and that the state has a real need to expand residential treatment services to all areas.

Thank you for considering this request. If there is any other information you need or want, please give me a call at the number listed above.

Sincerely,

Angie Gerock Banther MHDL, LCAS, CCS
Director of Clinical Services/Asst. Director

LT/BH COMMITTEE

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Material Related To

Intermediate Care Facilities for the Mentally Retarded

For the Final 2008 SMFP

September 14, 2007

Table 17C: Excluded Beds
Table 17D: Need Determinations

Comments: Elizabeth Huesemann- Irene Wortham Center

TABLE 17C: BEDS EXCLUDED FROM ICF/MR INVENTORY - Final 2008 SMFP

Facility Name	HSA	Mental Health Planning Area		Number of Certified Beds	Reason for Exclusion
Western Carolina Ctr.	I	4	Foothills	493	State Facility
Murdoch Center	II	15	Five County	660	State Facility
O'Berry Center	IV	30	Eastpointe	485	State Facility
Caswell Center	IV	30	Eastpointe	813	State Facility
State Facility Total				2,451	
Carolina Living & Learning	II	13	Orange-Person-Chatham	15	Demonstration Project
Group Homes for the Autistic	III	8	Piedmont Behavioral	15	Demonstration Project
Howell's A&B	IV	26	Pitt County	30	Demonstration Project
Demonstration Project Total				60	
Total Excluded Beds				2,511	

(t17C2008f) 9/5/2007

Table 17D: Need Determination for Transfer of Existing Certified ICF/MR Beds from State-Operated Developmental Centers Per Policy ICF/MR-2

(Scheduled for Certificate of Need Review during 2008)

HSA	County	Adult Bed Need Determination	CON Application Due Date	CON Beginning Review Date
I	Buncombe	6	To be determined	To be determined
II	Guilford	6	To be determined	To be determined
III	Mecklenburg	6	To be determined	To be determined
IV	Wake	6	To be determined	To be determined
V	New Hanover	6	To be determined	To be determined
VI	Pitt	6	To be determined	To be determined
	TOTAL	36		

Need determinations as shown in this document may be increased or decreased during the year pursuant to Policy GEN-2 (See Chapter 4)

**Application Due Dates are absolute deadlines. The filing deadline is 5:30 p.m. on the Application Due Date. The filing deadline is absolute (See Chapter 3)

(t17D2008f.xls) 9/5/2007

Asheville PH
July 13, 2007

TO: NC State Health Coorinating Council
FROM: Elizabeth Huesemann, Ex. Dir., Irene Wortham Center, Asheville, NC
RE: 2008 SMFP: Transfer of ICF/MR beds
DATE: July 13, 2007

Policy ICF/MR-2 : Transfer of ICF/MR beds from state operated developmental centers to community facilities for individuals who currently occupy the beds

Does not expand services, only relocates the services; thus does not make a bed available for anyone currently in need of a bed and not being served, and especially children.

Policy ICF/MR-1: Transfer of ICF/MR beds from state operated developmental centers to community facilities for medically fragile children.

There does not appear to be a "need determination" finding in the 2008 SMFP. Where are these beds to be located and how many are determined to be needed?

In MH Area I (Jackson, Haywood, Macon, Cherokee, Clay, Graham, Swain) there are 5 ICF/MR group homes with a total of 29 beds, none of which are children's beds.

In MH Area II (Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey) there are 17 ICF/MR group homes with a total of 160 beds. Of these beds, 12 are for children/adolescents with autism. Of the other 148 beds, up to 12 can be used for children.

Thus for the entire Mental Health Areas I and II, a 15 county area, the maximum number of children's beds is 12 or an allocation on average of less than 1 bed per county. Even in the absence of "hard" numbers, population probability would indicate this is an insufficient number of beds to serve these 2 areas.

Under either Policy #1 or #2, are funds being allocated for construction and start-up for new community facilities?

Proposed 2003 SMFP

POLICY ICF/MR-1: TRANSFER OF ICF/MR BEDS FROM STATE OPERATED DEVELOPMENTAL CENTERS TO COMMUNITY FACILITIES FOR MEDICALLY FRAGILE CHILDREN

ICF/MR beds in state operated developmental centers may be relocated to community facilities through the Certificate of Need process for the establishment of community ICF/MR facilities to serve children ages birth through six years who have severe to profound developmental disabilities and are medically fragile. This policy allows for the relocation or transfer of beds only and does not provide for transfer of residents with the beds. State operated developmental center ICF/MR beds that are relocated to community facilities shall be closed upon licensure of the transferred beds.

Facilities proposing to operate transferred beds shall submit an application to the Certificate of Need Section demonstrating a commitment to serve children ages birth through six years who have severe to profound developmental disabilities and are medically fragile. To help ensure the relocated beds will serve these residents such proposal shall include a written agreement with the following representatives: Director of the Local Management Entity serving the county where the group home is to be located; the Director of the applicable state operated developmental center; the Chief of State Operated Services in the DMH/DD/SAS; the Secretary of the Department of Health and Human Services and the operator of the group home.

POLICY ICF/MR-2: TRANSFER OF ICF/MR BEDS FROM STATE OPERATED DEVELOPMENTAL CENTERS TO COMMUNITY FACILITIES FOR INDIVIDUALS WHO CURRENTLY OCCUPY THE BEDS

Existing certified ICF/MR beds in state operated developmental centers may be transferred through the Certificate of Need process to establish ICF/MR group homes in the community to serve persons with complex behavioral challenges and / or medical conditions for whom a community ICF/MR placement is appropriate, as determined by the individual's treatment team and with the individual / guardian being in favor of the placement. This policy requires the transfer of the individuals who currently occupy the ICF/MR beds in the developmental center to the community facility when the beds are transferred. The beds in the state operated developmental center shall be closed upon certification of the transferred ICF/MR beds in the community facility. Providers proposing to develop transferred ICF/MR beds, as those beds are described in this policy, shall submit an application to the Certificate of Need Section that demonstrates their clinical experience in treating individuals with complex behavioral challenges or medical conditions in a residential ICF/MR setting. To ensure the transferred beds will be used to serve these individuals, a written agreement between the following parties shall be obtained prior to development of the group home: Director of the Local Management Entity serving the county where the group home is to be located, the Director of the applicable developmental center, the Chief of State Operated Services in the N.C. Division of Mental Health/ Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS), the Secretary of the Department of Health and Human Services and the operator of the group home.

POLICIES APPLICABLE TO ALL HEALTH SERVICES (GEN)

The policy statements below apply to all health services including acute care (hospitals, ambulatory surgical facilities, operating rooms, rehabilitation facilities, and technology); long-term care (nursing homes, adult care homes, Medicare-Certified home health agencies, end-stage renal disease services and hospice services); mental health (psychiatric facilities, substance abuse facilities, and intermediate care facilities for the mentally retarded) and services and equipment including bone marrow transplantation services, burn intensive care services, neonatal intensive care services, open heart surgery services, solid organ transplantation services, air ambulances, cardiac catheterization equipment, heart-lung bypass machines, gamma knives, linear accelerators, lithotriptors, magnetic resonance imaging scanners, positron emission tomography scanners, simulators, major medical equipment as defined in G.S. 131E-176(14f), and diagnostic centers as defined in G.S. 131E-176(7a).

POLICY GEN-1: REALLOCATIONS

(1) Reallocations shall be made only to the extent that the methodologies used in this Plan to make need determinations indicate that need exists after the inventories are revised and the need determinations are recalculated.

(2) Beds or services which are reallocated once in accordance with this policy shall not be reallocated again. Rather, the Medical Facilities Planning Section shall make any necessary changes in the next annual State Medical Facilities Plan.

(3) Dialysis stations that are withdrawn, relinquished, not applied for, decertified, denied, appealed, or pending the expiration of the 30 day appeal period shall not be reallocated. Instead, any necessary redetermination of need shall be made in the next scheduled publication of the Dialysis Report.

(4) Appeals of Certificate of Need Decisions on Applications
Need determinations of beds or services for which the CON Section decision to approve or deny the application has been appealed shall not be reallocated until the appeal is resolved.

(A) Appeals resolved prior to August 17:
If such an appeal is resolved in the calendar year prior to August 17, the beds or services shall not be reallocated by the CON Section; rather the Medical Facilities Planning Section shall make the necessary changes in the next annual State Medical Facilities Plan, except for dialysis stations which shall be processed pursuant to Item (3).

(B) Appeals resolved on or after August 17:

Table 17A: INVENTORY OF ICF/MR FACILITIES & BEDS for Proposed 2008 SMFP

Mental Health Area and Name of Provider	County	Approved, Not Yet Certified: Child	Approved, Not Yet Certified: Adult	CON Project Number	Total Beds Certif.	Certif Vendor Number	TOTAL BEDS (Appr. + Cert.)
MH AREA 1: Jackson, Haywood, Macon, Cherokee, Clay, Graham, Swain							**Smoky Mountain**
Macon ICF/MR Group Home #1(Second Street, Franklin)	Macon			2959/4171	6	346469	6
Macon ICF/MR Group Home #2(Iotla St., Franklin)	Macon			4289	6	346603N	6
Haywood County G. H. (Oak Park Dr.)	Haywood			2651	5	346374	5
Webster Children Group Home	Jackson			3878	6	346012	6
Smoky Mountain ICF/MR Group Home (11 Dills St.)	Jackson			1618/5046	6	346384	6
TOTAL AREA 1		0	0		29		29
MH AREA 2: Buncombe, Henderson Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey							**Blue Ridge**
Blue Ridge Home, Swannanoa (91 Poplar Circle)	Buncombe			4888/2294	37	346434	37
Irene Wortham Group Home (1 Rose St.)	Buncombe			4850/2628	11	346413	11
Irene Wortham Residential Center (16 Azalea St.)	Buncombe			3678/4175	6	346593	6
Dogwood Group Home (2 Rose St.)	Buncombe				6	346101	6
KHA (177 New Stock Road, Weaverville)	Buncombe			5059	6		6
Chiles Ave. Group Home (22 Chiles Ave.)	Buncombe			5330/2958	6	346410	6
Kenmore St. Group Home/Autistic Children (1 Kenmore St.)	Buncombe			4309	6	34604M	6
Pisgah Group Home (28 Pisgah View Ave-Asheville)	Buncombe			3880	6	346449	6
Montford Group Home - Autistic (406 Montford Ave.)	Buncombe			4855	5	34609W	5
Ora Street Group Home For Autistic (95 Ora St., Asheville)	Buncombe			3881	6	346322	6
Country Cove Group Home	Henderson			4773/2622	6	346402	6
Pinebrook ICF/MR Family Care Ctr (Erkwood Drive)	Henderson			3996	6	34601U	6
Rayside ICF/MR (617 & 619 Ray Street-Hendersonville)	Henderson			4758/4759	8	34609V	8
Ctr Mental Retardation of Madison (199 Wall Road)	Madison			229a	32	346438	32
VOCA Woodland Group Home, Woodland Dr.	Rutherford			4003	6	34603Y	6
VOCA Corp., Rollins Road, Forest City	Rutherford			4006	6	34604X	6
Forest Bend Group Home (S. Oak St., Brevard)	Transylvania			2956/3997	6	34604E	6
TOTAL AREA 2		0	0		160		160
MH AREA 3: Alleghany, Ashe, Avery, Watauga, Wilkes							**New River**
New River Cottage, Inc (82 Davis Lane)	Alleghany			2074/6400	5	346317	5
Ridgecrest I (West Jefferson)	Ashe			3482/3586	6	346130	6 *
Ridgecrest II (West Jefferson)	Ashe			3481/3587	6	346130	6 *
Thomas Street Home (Jefferson)	Ashe			3480/3588	6	346150	6 *
VOCA-Bluefield Court	Wilkes		1	5728/6349	5	346365	6
VOCA-College Street	Wilkes		1	5729/6350	5	346085	6
VOCA-Kinney Care Center I	Watauga			5731/6347	6	346528	6
Wildcat Group Home	Watauga			2661	15	346549	15
Western Health Care (Lakewood)	Wilkes			3827	6	34601B	6
Lewis Fork I and II (Ferguson)	Wilkes			2657	12	346512	12 **
VOCA-Wellborn	Wilkes			5732/6348	6	346510	6
VOCA-Apple Valley Care Center II	Wilkes			3426/5473	6	34604E	6
TOTAL AREA 3		0	2		84		86

*Bed count includes one Thomas S. bed. **Bed count includes two Thomas S. beds

7,425,183 / 3,222 = 2,305 beds instead of 5,252 beds

Comparison of North Carolina to Other States and Need Determination Methodology

If North Carolina used any of the individual state's ratios above or need methodologies (except for South Carolina's), the need for ICF/MR beds would indicate that the present number of 5,252 beds providing service in the state is an adequate number of beds.

If North Carolina used the average of the ratios for people per bed from the above four states the need for ICF/MR beds would equal to 1,870 beds:

7,425,183 / 3,970 = 1,870 beds instead of 5,252 beds

In the State of Tennessee's Health Guidelines for Growth, it is stated

"The population-based estimate of the total need for ICF/MR facilities is .05 percent of the general population. This estimate is based on the estimate for all mental retardation of 1 percent. Of the 1 percent estimate, 5 percent of those are estimated to meet level 1 criteria and be appropriate for ICF/MR services."

If North Carolina used the .05 percent of its general Year 2007 population, the need for ICF/MR beds would equal to 4,484 beds:

8,968,800 x .01 = 89,688 x .05 = 4,484 beds instead of 5,252 beds

The Division of Facility Services' basic position continues to be that additional ICF/MR beds in North Carolina is in conflict with the experience and practice of surrounding states that indicate that North Carolina has a more than adequate number of ICF/MR beds in comparison to other Southeastern states.

Need Determination for ICF/MR Beds

It is determined that there is no need for additional ICF/MR beds anywhere else in the state.

Sources of Data

ICF/MR Beds Operational:
Certification Section, Division of Facility Services, N.C. Department of Health and Human Services

ICF/MR Beds Available:
Certificate of Need Section, Division of Facility Services, N.C. Department of Health and Human Services

TABLE 17C: BEDS EXCLUDED FROM ICF/MR INVENTORY - Final 2007 SMFP

Facility Name	HSA	Mental Health Planning Area		Number of Certified Beds	Reason for Exclusion
Western Carolina Ctr.	I	4	Foothills	493	State Facility
Murdoch Center	II	15	Five County	660	State Facility
O'Berry Center	IV	30	Eastpointe	485	State Facility
Caswell Center	IV	30	Eastpointe	813	State Facility
State Facility Total				2,451	
Carolina Living & Learning	II	13	Orange-Person-Chatham	15	Demonstration Project
Group Homes for the Autistic	III	8	Piedmont Behavioral	15	Demonstration Project
Howell's A&B	IV	26	Pitt County	30	Demonstration Project
Demonstration Project Total				60	
Total Excluded Beds				2,511	

(t17C2008p) 6/21/2007

Table 17D: Need Determination for Transfer of Existing Certified ICF/MR Beds from State-Operated Developmental Centers Per Policy ICF/MR-2

(Scheduled for Certificate of Need Review during 2008)

HSA	County	Bed Need Determination	CON Application Due Date	CON Beginning Review Date
I	Buncombe	6	To be determined	To be determined
II	Guilford	6	To be determined	To be determined
III	Mecklenburg	6	To be determined	To be determined
IV	Wake	6	To be determined	To be determined
V	New Hanover	6	To be determined	To be determined
VI	Pitt	6	To be determined	To be determined
	TOTAL	36		

Need determinations as shown in this document may be increased or decreased during the year pursuant to Policy GEN-2 (See Chapter 4)

**Application Due Dates are absolute deadlines. The filing deadline is 5:30 p.m. on the Application Due Date. The filing deadline is absolute (See Chapter 3)

(t17D2008p.xls) 5/10/2007